

REFLECTION, RECOLLECTION, AND CHANGE: ORAL HISTORIES OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

Interviewee: Eighteen associates of the Nevada State Board of Medical Examiners

Interviewed: 1994-1995

Published: 1996

Interviewer: Anita E. Watson

UNOHP Catalog #167

Description

In 1899, the nineteenth legislature of the state of Nevada wrote the law that created the Nevada State Board of Medical Examiners. The background to that statute, nationally and in Nevada, as well as the development of the Board into the modern, regulatory organization that it has become, was explored in the first volume of this work, *Recollection, Reflection, and Change: The Nevada State Board of Medical Examiners*.

The statute that established the Board was a collection of words that mandated responsibilities and provided opportunities for medical oversight. The history of the Board can be found in those words and others. The records of the legislature, Board meeting minutes, files and correspondence, governor's documents, newspaper accounts, and secondary histories—all chronicle the activities of the Board.

The *life* of the Board, however, can be found in the oral histories. It was individuals who truly created the Board of Medical Examiners. The men and women who have been members of the Board and who have worked with both the Board and medicine in Nevada are the individuals who created this enterprise. Their backgrounds, their personalities, their actions, their personal visions—all have breathed life into the Board over its near century of existence. And in turn, the history of the Board is brought to life through the reminiscence and recollections of individuals.

For the oral history of the Board, eighteen individuals were interviewed. They represent a variety of experiences and of connections to the Board and to medicine. Most were physicians, but some were lay members of the Board. Most were on the Board, but some were connected only through their own examination and licensing experience.

The experiences that individuals brought to medicine and the Board varied widely, and have been covered rather extensively in the interviews. From bullfighting in Spain to a breeches buoy in the Sulu Sea to civil rights involvement in the southern United States—the backgrounds, education and training, and interests of the physicians and Board members have influenced their activity while on the Board, and, thus, are an important part of its history, as well as the history of medicine in Nevada.

Change is the overriding theme in these interviews—change in the individuals themselves, change in medical oversight, change in their communities, and change within the state. Change was not always sought and often not welcome. Some are pleased with the transformations that they have experienced and observed; many mourn the passing of the familiar. All, however, recognize the inevitability of change, and offer thoughtful commentary on the history, and personal and professional transformations, that they have witnessed.

Continued on next page.

Description (*continued*)

Involvement with the Board of Medical Examiners and medicine has resulted in mixed responses, in the form of important friendships, fond memories, and recollection of anger and frustration. None of the individuals interviewed were neutral about the Board, medicine, or the changes they have witnessed. Their contributions, memories and opinions add important depth and dimension to the words on paper. This rich perspective is apparent in the reflection and recollection in the oral histories in this volume.

**REFLECTION, RECOLLECTION, AND CHANGE:
ORAL HISTORIES OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS**

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THIS PROJECT WAS MADE POSSIBLE IN PART BY A GRANT
FROM THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

An Oral History Conducted by Anita Ernst Watson
Edited by Anita Ernst Watson

University of Nevada Oral History Program

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Printed in the United States of America

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PREFACE TO THE DIGITAL EDITION

Established in 1964, the University of Nevada Oral History Program (UNOHP) explores the remembered past through rigorous oral history interviewing, creating a record for present and future researchers. The program's collection of primary source oral histories is an important body of information about significant events, people, places, and activities in twentieth and twenty-first century Nevada and the West.

The UNOHP wishes to make the information in its oral histories accessible to a broad range of patrons. To achieve this goal, its transcripts must speak with an intelligible voice. However, no type font contains symbols for physical gestures and vocal modulations which are integral parts of verbal communication. When human speech is represented in print, stripped of these signals, the result can be a morass of seemingly tangled syntax and incomplete sentences—totally verbatim transcripts sometimes verge on incoherence. Therefore, this transcript has been lightly edited.

While taking great pains not to alter meaning in any way, the editor may have removed false starts, redundancies, and the “uhs,” “ahs,” and other noises with which speech is often liberally sprinkled; compressed some passages which, in unaltered form, misrepresent the chronicler's meaning; and relocated some material to place information in its intended context. Laughter is represented with [laughter] at the end of a sentence in which it occurs, and ellipses are used to indicate that a statement has been interrupted or is incomplete...or that there is a pause for dramatic effect.

As with all of our oral histories, while we can vouch for the authenticity of the interviews in the UNOHP collection, we advise readers to keep in mind that these are remembered pasts, and we do not claim that the recollections are entirely free of error. We can state, however, that the transcripts accurately reflect the oral history recordings on which they were based. Accordingly, each transcript should be approached with the

same prudence that the intelligent reader exercises when consulting government records, newspaper accounts, diaries, and other sources of historical information. All statements made here constitute the remembrance or opinions of the individuals who were interviewed, and not the opinions of the UNOHP.

In order to standardize the design of all UNOHP transcripts for the online database, most have been reformatted, a process that was completed in 2012. This document may therefore differ in appearance and pagination from earlier printed versions. Rather than compile entirely new indexes for each volume, the UNOHP has made each transcript fully searchable electronically. If a previous version of this volume existed, its original index has been appended to this document for reference only. A link to the entire catalog can be found online at <http://oralhistory.unr.edu/>.

For more information on the UNOHP or any of its publications, please contact the University of Nevada Oral History Program at Mail Stop 0324, University of Nevada, Reno, NV, 89557-0324 or by calling 775/784-6932.

Alicia Barber
Director, UNOHP
July 2012

ORIGINAL PREFACE

Oral histories can be rich sources of information about the past. At their best they also reveal the human dimension of history that is so often missing from historical documents. However, by its very nature the oral historian's methodology is fundamentally limited in application: the practitioner can explore only the remembered past.

Dr. Tom Scully, secretary-treasurer of the State Board of Medical Examiners, approached me in 1993 about starting a project on the history of the board. I agreed with him that such a project was needed, but the board was established in 1899, which put the first forty years of its operations effectively beyond the reach of oral history. Furthermore, much of what constituted the "history" of the board could be better reconstructed from written documentation than from the memories of a relatively small percentage of the total number of physicians who had served on it. I recommended a hybrid project—one that was oriented toward traditional historiography, but

that included as much oral history as was appropriate.

In the end, that was the approach taken. History and oral history collaborated. With funding from the board, and with guidance from history professor Elizabeth Raymond, Anita Watson, a Ph. D. candidate in the history department of the University of Nevada, Reno, spent two years researching and writing an excellent history of the Nevada Board of Medical Examiners. (*Reflection, Recollection and Change: The Nevada State Board of Medical Examiners*, by Anita E. Watson. Reno: UNOHP, 1996.) As part of her research, during 1994 and 1995 Ms. Watson conducted eighteen tape-recorded oral history interviews. The University of Nevada Oral History Program (UNOHP) transcribed the tapes, provided Ms. Watson with some editorial assistance, and formatted and printed the finished works which are here presented bound together. These oral histories are important supporting adjuncts to Ms. Watson's history of the Board. They

will also be of value to researchers pursuing other, related interests.

It was a pleasure to work with Anita Watson, Professor Raymond, Dr. Scully, and Larry Lessly, the board's legal counsel. All parties to this project did everything they could to ensure its success, and succeed it did. The UNOHP is pleased to add these important oral histories to its collection.

Tom King
UNOHP Director

INTRODUCTION

In 1899, the nineteenth legislature of the state of Nevada wrote the law that created the Nevada State Board of Medical Examiners. The background to that statute, nationally and in Nevada, as well as the development of the Board into the modern, regulatory organization that it has become, was explored in the first volume of this work.

The statute that established the Board was a collection of words on paper, words that mandated responsibilities and provided opportunities for medical oversight. The history of the Board can be found in those words and others. The records of the legislature, Board meeting minutes, files and correspondence, governor's documents, newspaper accounts, and secondary histories — all chronicle the activities of the Board.

The life of the Board, however, can be found in the oral histories. It was individuals who truly created the Board of Medical Examiners, the men and women who have been members of the Board and who have worked with both the Board and

medicine in Nevada. Their backgrounds, their personalities, their actions, their personal visions — all have breathed life into the Board over its near century of existence. And the history of the Board is brought to life through the reminiscence and recollections of individuals.

For the oral history portion of the Board's story, eighteen individuals were interviewed. They represent a variety of experiences and of connections to the Board and to medicine. Most were physicians, but some were lay members of the Board. Most were on the Board, but some were connected with the Board only through their own examination and licensing experience.

The interviews vary as widely as the individuals involved. Several are extensive and cover, in some detail, a variety of topics. Others are briefer and limited in their discussion. The histories have been only lightly edited, primarily to clarify meaning and to provide chronological order. The interviews were essentially conversations.

Some were conducted in a leisurely manner over ice tea around kitchen tables; others consisted of moments snatched in busy offices, between patients and telephone calls.

The experiences that individuals brought to medicine and the Board also varied widely, and have been covered rather extensively in the conversations. From bullfighting in Spain to a breeches buoy in the Sulu Sea to civil rights involvement in the southern United States — the backgrounds, education and training, and interests of the physicians and Board members have influenced their activity while on the Board, and, thus, are an important part of its history, as well as the history of medicine in Nevada.

The histories are illuminating. Change is the overriding theme in these conversations — change in the individuals themselves, change in medical oversight, change in their communities, and change within the state. Change was not always sought and often not welcome. Some are pleased with the transformations that they have experienced and observed; many mourn the passing of the familiar. All, however, recognize the inevitability of change and offer thoughtful commentary on the history, personal and professional, that they have witnessed.

Involvement with the Board of Medical Examiners and medicine has resulted in mixed responses, in the form of important friendships, fond memories, and recollection of anger and frustration. None of the individuals interviewed were neutral about the Board, medicine, or the changes they have witnessed. Their contributions, memories and opinions add important depth and dimension to the words on paper. This rich perspective is apparent in the reflection and recollection in the oral histories that follow.

Each oral history is prefaced by a brief biographical sketch. For the reader's

convenience, the histories have been placed in alphabetical order, and the interviewer's questions have been set in italics.

Anita E. Watson
University of Nevada, Reno

M. RONALD AVERY, M.D.

Dr. M. Ronald Avery was born in Lake Village, Arkansas, in 1936. He attended school there, graduating from high school in 1954. He received a B.S. in Chemistry from the University of Arkansas, Monticello, in 1958, continuing on at the University of Arkansas School of Medicine, where he received his M.D. in 1962. He served a rotating internship in Shreveport, Louisiana, and a four-year residency in OB/GYN at the University of Arkansas Medical Center in Little Rock, completing that training in 1968. He was a captain, a general medical officer, in the United States Air Force, stationed in Greenville, Mississippi.

Dr. Avery moved to Reno and entered private practice in 1968. He is an assistant clinical professor of obstetrics and gynecology with the UNR School of Medicine, and is active in medical politics. He has also been chief of the department of obstetrics and gynecology at St. Mary's and was a member of the Board of Medical Examiners from 1985 to 1993. He was named the A.H. Robbins Physician of the Year by the Nevada State Medical Association in 1990.

M. Ronald Avery, M.D.: I was born in Lake Village, Arkansas, on October 3, 1936. I grew up there, lived all of my young life in Lake Village, which is a small town in southeast Arkansas. The population there when I was in high school was about fifteen hundred people.

My father was assistant postmaster for many, many years, and then he was the administrative assistant to the county judge for another thirteen or fourteen years after he retired from the postal service. My mother worked for the bank in Lake Village as a teller. My mother was the oldest of seven children and she's still alive. She's seventy-eight. My father just died this year [1994] in May; he developed an acute myelocytic leukemia.

I have a sister and a brother. I am the oldest but my sister and I grew up together. My brother was twelve years younger than me, and my sister was three years younger.

I went to high school at Lakeside High School, and graduated in 1954. During the years we were growing up, we lived in a house where my grandmother lived. She was a very

intelligent person; my grandfather died when I was six, but my grandmother lived to be 101, and died in 1980. She had a lot of influence in my life, as well as my parents.

I grew up with two of my closest friends. Their fathers were both physicians, and they're both physicians now. We spent a lot of time at the hospital when I was very young. I just always decided I wanted to be a physician. Interestingly, in my high school class, there were thirty-four graduates in our class, and there're three physicians out of that thirty-four, which is a fairly good size percentage.

You really had to have a lot of motivation to be able to get out of the environment. The economic environment in the Mississippi delta is extremely poor, and so you're really motivated, in a way, to do something and go to school, because you couldn't pick enough cotton to make enough to even buy a meal. In fact, I couldn't pick enough cotton to eat one meal a day.

Anita Watson: It was primarily agricultural?

Right. It is still primarily agriculture.

If you hadn't gone on to college and become a physician, what else could you have done?

Well, if you didn't go to college at all, casual labor would have been about the only thing that you would have been able to do. Or drive a truck. During the summers, in high school, I did several things. I drove a dump truck one summer; made a dollar an hour hauling gravel.

Another two summers, we seined the bar pits for the Game and Fish Commission. The bar pits are areas along the Mississippi River where they bar the dirt to build the levees along the Mississippi. We only lived about four or five miles from the Mississippi River.

The seine is a big net; it would maybe be fifty feet long. We would go out into these bar pits after game fish, but we would catch maybe forty or fifty snakes every time we pulled it through. We got attacked in the water many times by snakes.

Are these cotton mouths?

There were all kinds, most of them water snakes, but there were water moccasins and cotton mouths — all kinds of poisonous snakes. This area's full of wildlife, and we'd catch all sorts of things. We would take the game fish and put them in barrels and then into a truck. Then we would take them and put them in different lakes. We did this a couple of years, and we got a \$1.00 an hour.

They would have teenagers doing this type of work because everybody else was smart enough not to do this. You had to be crazy and think you were invincible to do that sort of thing. We were lucky; none of us really had gotten bitten by a poisonous snake.

This kind of work can be an important motivation for going on to school? [laughter]

Yes. You thought about the things that you could do. In small towns like that you also went out for football and basketball and track. You went out for all the sports, and you found out real quick that you weren't going to make any money in the sporting world, unless you were an extremely good athlete. There were several that came out of Lake Village who did play professional football.

I wasn't talented in that direction, even though I thought I was an athlete in high school. I can look back and know that I wasn't, but it kept me from drinking and smoking, which I never did. I never drank until I was over twenty-one; of course, I didn't

have any money in that area. Those kind of motivations, thinking you were an athlete and thinking you shouldn't drink and you shouldn't smoke, kept you from doing some of the things that you might otherwise have done at an early age. That was always helpful.

I had a motorcycle. Of course, I wouldn't let any of my children have motorcycles because I knew what I did, and I felt like I was a lot more mature at a younger age than my children were. I used it for paper routes I had from the time I was real young, maybe in the sixth grade, until eleventh grade in high school. We also used it to play chase and things at night. We would run all over town. Several of the guys had pretty bad wrecks and got hurt some nights when we were out playing chase. I remember, we'd go through backyards, and, of course, you couldn't see, and you'd hit a clothesline right across the chest. You'd be sitting on the ground trying to catch your breath, and your motorcycle would be going off into somebody's house. [laughter]

We had lots of fun doing that, but it was also very dangerous. Actually, we didn't believe we had much to lose when we were growing up because we never figured that we had anywhere to go or much to do. If you made it, great. If something happened and you died, well, it really wasn't that important. You know, it just happened.

Do you think it might be similar to the attitude they talk about now in the ghettos, the inner city ghettos?

Yes, I think definitely it is. These kids think they're invincible anyway, and then when they find out they aren't, they figure they haven't lost much. Only trouble is, you never know what you could have done if you're one of them that gets killed.

How did your family feel about your desire to get out of town, and to aspire to something that wasn't that common?

They didn't necessarily want me to get out of town, but they wanted me to aspire to do more. My father always wanted to do journalism, and my grandfather, his father, owned the Chicot Spectator, which was the local newspaper. They both worked on the newspaper, but then when the Depression came, my grandfather lost everything, and my father had to go to work elsewhere.

My father married young; he was only about twenty-one, and I was born a couple of years later. He was only about twenty-three then, and my mother was only about twenty, so they were young and they had to go to work. He had to quit college, and even though his brother was an electrical engineer and his younger sister got to go to college and get a degree in teaching, he didn't get to go to college, except for a year, a year and a half. He never got to work at what he wanted to do all his life, so he was disappointed, and he wanted me to have the chance for an education.

You mentioned the grandmother that you lived with.

She had a college degree in teaching. She was a very bright person. On my other side, my mother's father went to the sixth grade, and my mother's mother went to the eighth grade, and that's all the education they had. My mother's father just hunted and fished all of his life. He never did anything else.

Did he support his family that way?

Yes, that's the way he made his living. He would sell the fish and sell the game on the street. They never owned much of anything.

He owned this old truck, but that's about the only thing they ever owned, and I'm sure it cost \$100.00. They'd rent an old house, and pay about \$10.00 a month. It was always old and beat-up, and most of the time it didn't have indoor plumbing. They had an icebox instead of a refrigerator. They lived very, very poorly because they had seven children and probably seven miscarriages along the way. They both died at age sixty-seven.

My grandfather never worried about anything, [laughter] except about where the next meal might come from, and he knew how to catch it or kill it. He traded his wild game for beef and other things. So they always had plenty to eat.

But it's not possible to live that way anymore, do you think? Or are there still people who are doing that?

No, you can't live that way anymore. He just existed, and they had plenty to eat, but they didn't have anything else — at all. It was just an existence compared to a way of life as we know it, but they were happy. That's all that matters.

Do you think maybe happy because he felt he was in control of his life? Independent?

Oh, he was. He was in total control, and he didn't want anything more. He was doing what he wanted to do and he had total freedom. He didn't have to pay taxes. Didn't have to even file an income tax form; he didn't make enough money, and he didn't know how, anyway. He finally did start paying some social security, you know, later in life, but he didn't know how to do that. My dad took care of that for him. With no education at all, well, he didn't have the ability to even know how to do those things.

He couldn't read or write?

He could read a little bit, certain things, and he could write some, but not much.

My grandfather thought I was totally crazy to go to school and to be a physician. He thought that for me to spend this much time and effort and money to become a physician was absolutely crazy. He never saw a physician in his whole life; never saw a dentist in his whole life. Died of a heart attack in his sleep, and never was sick, that I remember, in his whole life.

Do you remember what kind of medical care they would have had from that poverty-stricken background?

My grandmother had diabetes and had other problems. Most of her medical care was at the University Hospital in Little Rock, where all the people that had no money ended up. Any inpatient care just about had to be done there, and there was very little outpatient care.

Would those seven babies have been born at home?

Oh, yes.

Delivered by a midwife?

No, just delivered. You might call somebody a midwife, but they had no training of any sort. There may have been a few of them that were born in a hospital, because I do have an aunt that's from my mother's side that's just a year older than I am.

So they had very minimal care. Like I say, my grandfather never saw a physician his whole life. He would have died, probably, if he would have had any serious problems,

but he was a very strong person because of the work he did. Hunting and fishing is very difficult work.

I did professional fishing between my junior and senior year in high school. We lived right on a big lake, Lake Chicot. You get up at 3:00 in the morning, and you catch the sardines or the minnows that you need to bait your lines with. You go out and bait your lines, and then you run them early, and then you have to re-bait them and run them later in the afternoon. You go clean and sell the fish in the meantime. It's really very grueling work; one summer was enough for me. I did enough different things along the way to find out that getting an education was a wise thing to do.

I was lucky enough to be able to do that, because my family was not well-to-do at all when I went to college. I went to Arkansas A & M, which was close by, because it was the most inexpensive place to go. I would work in the summertimes, and I would eat in my room. I didn't have enough money to buy a cup of coffee, even, so I would have water at the commissary. I would hitchhike when I went home, and, of course, most people didn't have cars, so that wasn't unusual then. I would go home frequently on the weekends or every few weeks, and take all my laundry and have it done at home. It was only sixty miles away, so it wasn't that far, in Monticello, Arkansas. I got a B.S. in chemistry in 1958.

I was accepted to the University of Arkansas to medical school, and started in 1958, and graduated in 1962. I did my internship at Confederate Memorial Medical Center in Shreveport, Louisiana, a rotating internship which they don't have now.

At that time nearly everybody in my class was drafted, except for a very few people with political connections. You either had a choice of being drafted, or you volunteered to go in as a captain, so I went in as a general medical

officer in the air force. I was stationed at Greenville, Mississippi.

Shreveport, where you did your internship, is fairly close to where you were raised, isn't it?

Yes, it's in northern Louisiana, and it's only 200 miles from my home town. Little Rock's about 135 miles from my home town. When I applied to the air force, I applied to go to California, and they sent me to Greenville, Mississippi, which is across the river, 20 miles away from where I grew up. I spent all of my younger life until I moved here, right in that area of the south.

I had two little trips away from Greenville. I went through Basic Training. They sent us three weeks to Basic Training in Montgomery, Alabama, and we learned how to march, and to clean our guns, and take them apart and put them together, and that sort of thing. That was a different experience.

We were all general medical officers. One of the general medical officers had a year of surgery, so he was the surgeon, and one of them had a year of internal medicine, so he was the internist. They sent me to Keesler Air Force Base in Biloxi, Mississippi, for three weeks, and I became the radiologist.

You just couldn't get out of the south, could you? [laughter]

[laughter] No, I spent quite a bit of time in the south, so I know the south pretty well. I'll always be a southerner no matter where I live because that's where my roots started. And still are, I guess, in that respect, since I'm the only one that really left home out of the family.

When I was the radiologist at the base, I tried real hard to talk myself into going into radiology because I knew it would be

a much better lifestyle, even though at that time I didn't really care whether I made much money or not because that didn't mean anything. I never had any, so it didn't matter whether I had it or not — everything seemed to work out. But I just couldn't get away from the patient contact. I really like people, and I really wanted to stay with something where I had a close association with people.

The base at Greenville, Mississippi was closed while I was there, so I got out about seven months early from my two-year assignment. You either had to extend for an extra year, or you had to get out. I chose to get out, and I was lucky enough to start my residency the very next day in obstetrics and gynecology at the University of Arkansas.

So I went back to Little Rock for a four-year residency. I was fortunate that I only had to spend about eight months as a first-year resident, and then they needed me to move on to be a second-year resident, and I finished in three years and seven months.

Were you entitled to the GI Bill to help you get through your residency?

Yes. I got married in 1962, and my wife worked. She had graduated from St. Olaf College in Northfield, Minnesota with a B.S. in Nursing. She went to work actually when I was an intern in Shreveport, and then she got a job teaching pediatric nursing in Little Rock at St. Vincent's Hospital. I got another \$130.00 a month, if I remember correctly, for about a year and a half from the GI Bill during that period of time. As an intern, I made \$120.00 a month. As a first-year resident, in 1964, I made \$275.00 a month. As a second-year resident, I made \$300.00 a month. As a third-year resident, I made \$325.00 a month. And as a fourth-year resident, we were considered instructors, and we made \$500.00 a month. So we made a lot more.

But nearly all of us had to moonlight, and by moonlighting, I mean we had to work in ERs and find other jobs to make enough money. Even with your wife working, it was difficult to make ends meet on those kind of salaries, so we would work in emergency rooms if we had any time off. You couldn't do very much work the first year because you were on thirty-six hours and off twelve. It's difficult to work beyond that very much.

At the end of your thirty-six hours, you just went home and collapsed?

Right. You just went home and went to bed. But, even if you didn't have down time, you really spent a lot of time reading every time you had a chance, and discussing things with other people during the night. As you were a younger resident, you would discuss cases and all types of things with the older residents every time you had a chance. Then the same thing worked when you were an older resident; you'd spend more time visiting with the younger residents. As a fourth-year resident, the second six months of the fourth year, you didn't have to stay in the house when you were on call. You could take calls from home. But all the other years, you had to stay in the house; you didn't have a choice.

What made you choose OB?

Well, OB/GYN has a variety of things with it. It is more like primary care, but it's primary care for women, and you can eliminate the parts of primary care that you don't really like. You have a lot of psychology and psychiatry involved. You've got patient care, a lot of patient contact, which, as I said, I like. You have surgery and you have delivery. So you really have a wide variety of things that you can do. I always like obstetrics the best, but

as you get older, doing obstetrics like I did, was difficult. When you're not in a big group, and you're on every night and every other weekend for years and years and years, it wears you down, and you've got to decide how long you're going to do it. I decided that I would do obstetrics until I was about fifty-five, and then quit. That's what I did. I quit three years ago, and stopped delivering babies.

Life is so different and better. It seems like I'm semi-retired just working in the daytime. The night work is what's hard. Obstetrics is hard in a lot of ways. You were always worried about a lot of people. There was never any time that you didn't have somebody that was not having problems. It always affects you, more that you realize until you quit. You think that's a normal way of life until you quit, and then you realize what an abnormal life you've lived.

What made you decide to practice in Reno?

Well, Dr. Stewart and Dr. Bynum were in together at that time. Dr. Si Ross was one of their partners, and he had died in 1967, in October of 1967. His partners were looking for somebody to come out here. Bynum had gone to Arkansas, and so he knew my chief, Willis Brown, at Arkansas. He called him to see if anybody was interested. I hadn't found a place that I was really interested in going.

I'd been looking in the south. My wife was from San Diego and really wasn't too happy with some of the places where I was looking. So I came out here and looked the situation over. I couldn't afford to bring her because they were only going to pay my way if I accepted the offer. Otherwise, I had to pay my own way. I'd never been to Reno — in fact, I had to look it up on the map. I didn't even know where Reno was.

When I flew out here, I liked what I saw. Reno was a small, nice little town in 1968, and Lake Tahoe was beautiful. This just looked like the perfect place, so I just made the decision while I was here that I'd take the position, even though it was the lowest paying position I was offered in the United States, or anywhere that I'd looked.

Isn't that odd that Reno was the lowest paying position? I would think the ones in the south would have been far lower.

No, when I moved here, I was on a salary, and I made \$1200 a month the first six months, and then I would increase to \$1500 a month the second six months. That wasn't actually enough for us to live on in Reno. We didn't realize that the expenses would be that much higher than Little Rock, but it was about 25 percent higher to live here than it was in Little Rock. We had a hard time making ends meet when we first came here, because we had lots of debts.

In fact, I had to borrow \$1500 just to move from Little Rock to Reno. We, of course, hadn't accumulated any money during those years, and we had two children by then. We had a daughter who was born in 1964 when we were in the air force in Greenville, Mississippi, and then we had a son born in 1967 in the beginning of my last year of residency. So we had two children, we had an old car, and on the way out here, that car broke down in Henrietta, Oklahoma. We had to have the motor totally rebuilt, and it cost \$167 to have that done. We had to spend four days in Henrietta, Oklahoma, with two kids at a Holiday Inn. So we spent most of our \$1500 just getting here. [laughter]

Then we finally, finally made it out here. My wife had never been to Reno, and when we got here she hated it. Hated it for the first

two or three years we were here, and finally just adjusted to the situation. She's still not wild about it, but she likes it well enough now, I guess, because all the kids live around here. Anyway, this has been home for over twenty-six years now.

It's quite a contrast between the south and Reno.

But there's one thing, one big advantage of growing up in the south — if you grow up in the south you can live anywhere. If you grow up anywhere else, it's very hard to adjust to living in the south.

Why do think? What are the biggest differences?

Well, the mindset, I think, is the biggest difference. The south is a very close-knit group of people — it's a group of communities that are mainly rural or have been. They're small communities, even though they're numerous, they're just five miles apart. They're still very, very small communities. Everybody knows everybody, and unless you grow up in the south, everybody's very suspicious of you if you come in from the outside. You're an outsider. Even if I went back to the south now, I would be an outsider. I wouldn't be really a part of the network in the south anymore. It's just very, very different. Now if you go to the cities in the south, then it's not much different than cities most places, but in the smaller communities, it's very, very different.

Do you think there's anything like that in small towns in Nevada? Can you make a comparison?

I really haven't seen that as much in Nevada as it is in the south, but it probably is more so in the small towns than it would be in any of the cities. Gosh, when I came to Reno

it was a small town, a little under 100,000 at that time. There were no tall buildings in town; even Harrah's wasn't here. Harrah's tower was built in 1969. The only three tall buildings were Arlington Towers, the First National Bank Building, and that little fifteen-story apartment building right across from the river, Arlington Towers. That was it. There were no other high-rise buildings in Reno. And look at it today. That's a short period of time, twenty-five years or so, and now it looks like a city.

Coming to Reno from Little Rock, how did the practice differ, do you think? Or did it? Is there a commonality with your type of practice?

Yes, I don't think that there was that much difference in the way the practice is. All of our professors were from somewhere out of Arkansas. In other words, Willis Brown trained in Michigan, and he'd been at Arkansas for — it seems like forever. Even when I started, he'd probably been the head of the department for twenty years. The other people that were there really trained in different parts of the country, so we had a lot of different ideas and a lot of different aspects.

We had tremendous pathology in Arkansas. We got everything in the state, everything bad in the state. In obstetrics, we didn't have a big number of deliveries, but everyone of them was complicated. There were hardly any normal deliveries.

Why is that do you think?

They were all referred in. That was the only indigent center in the state at that time, so every indigent patient with any problems got sent there.

Did you see a lot of women with no prenatal care, who just started labor and the problems started?

Yes. Or the problems started before labor. We had a tremendous number of serious problems, serious pelvic abscesses, and even a lot of deaths related to a lot of those problems. We got a tremendous amount of vaginal surgery, and cancer training, that you can't get today in a residency. They just don't have the numbers. It was a real, real teaching hospital. But you still had enough time to read and to do other things, because we weren't just overwhelmed with volume. That made it an excellent experience. So we were real fortunate.

Was Reno, and the facilities that were available here, a contrast?

Not really, because Washoe and St. Mary's both had reasonably good facilities. They weren't as good as we had in Arkansas because Little Rock was a new facility. They had built a new hospital in 1960. I had graduated in 1962 and finished my residency in 1968, so the facilities there were excellent at the time. But we had good facilities here. We had all the adequate things. Some of them were a little outdated, but they worked. It wasn't like it was a big, big letdown because I'd had plenty of experience out in the rural areas where things were really bad.

In fact, I was even thinking about going into general practice after I got out of the air force. A friend and I were going to go in together, so I helped him set up his practice in a rural area in Mississippi. We had everything fixed up, and then I got accepted into the residency. I went on to the residency, and he went on into practice there.

Now that was bad. I mean, that was really backwards. They didn't have any physicians, nobody had any money, and the deliveries were just done wherever they fell. He started doing deliveries in his little clinic, but there

were no facilities except a place to get on a table and have a baby.

In addition to your practice in Reno, you have been active in medical politics. You were chief of OB at St. Mary's.

Yes, I've been chief of OB there on two occasions. Around 1970 I was chief of OB for two years, and then in 1979 and 1980, for two years again. As chief of OB, you're in charge of all of the organization of the department. You run the meetings, and take care of any problems that come up. Back in 1970, when I was first chief of OB, they didn't have an emergency room department—so the chief of OB saw all the walk-in OB/GYN patients, too. [laughter] That was a pretty rotten job then. Thank goodness, there weren't very many walk-ins because the emergency room was small back then, but you really saw everything. Things gradually matured to where there's a call schedule. Everybody participates until they're fifty-five, then you can go on Senior Active Staff, and you don't have to take call. That's a bonus of getting older. [laughter] There's got to be some bonuses to getting older [laughter] and that's one of them.

I have been active in the County Medical Society as a delegate to the State Medical Association, oh, the last fifteen or twenty years or more. I've been on the board of the County Medical Society.

What types of issues did you deal with as a delegate to the County Medical Society?

Just the same things that we deal with now: malpractice, smoking, and a whole gamut of things that are politically important to physicians.

You were on the Board of Medical Examiners from 1985 to 1993. How did you get involved in that?

Dick Bryan just happened to select me out of whoever had applied, because I had no political contacts at all. Anyone interested in being on the Board wrote a letter; then they got some other people to write letters for them. Actually Bob Clift ended up suggesting me, and helping me to get on the Board. I wasn't even thinking about it until he approached me. He's a urologist here in Reno, and he was on the Board at the time. He was secretary/treasurer, I think, from 1985 to 1987. He was a very good Board member, really worked hard, and did a good job. I was secretary/treasurer right after him.

Just before you came on the Board in 1985, the Medical Practice Act was revised. You were involved, essentially, in its implementation.

Right. The reason that I got on the Board is that the 1985 Medical Practice Act, as it went into effect, increased the number of members on the Board. Adding one physician and one public member, it increased the Board from seven to nine members. I was appointed to that extra position, so I didn't really take anybody's place.

As a physician, as a private individual, if you will, before going on the Board, did you have any feeling of the changes that the Medical Practice Act made. Did it have any impact on you?

Well, most people that practice medicine have very little involvement with the Board, the majority of people. Unless they're acting as consultants for the Board or unless they're doing things that the Board requests them to

do, they really are unaffected by the Board. New people coming into the state were affected in that you had to have had three years of postgraduate education after the 1985 act. People that didn't have that three years of postgraduate education after medical school couldn't apply for licenses. So that affected a certain number of people.

That really has not slowed down the number of applications nor the number of physicians coming in Nevada. It's been a plus, even though it's been revised several times since. It still requires the three years for people coming into Las Vegas and Reno. So it's upgraded, probably, the quality of people that are coming into the state.

Medical education has changed considerably. You got a lot of experience as a junior and senior in medical school, a lot of practical experience and a lot of delivery of health care. That doesn't happen much anymore in medical school; now it happens after medical school. When you just did an internship, which is another year, and you rotated through everything again, you were really better prepared to go out and practice medicine, but now you just don't have that number of encounters.

You really need the three years of training after medical school to have all that clinical contact to make you a much better physician. Most people are doing that three years postgrad and have been for quite a few years, so there's only a few people that this requirement affects. It affects the older physician who might want to move to Nevada to retire, or semi-retire, and practice medicine, and it affects a few of the younger physicians who drop out of their programs for one reason or another. They would have to seek other states to practice in. Now there are ways around that in Nevada but it still, I think, has helped the quality of medicine continue

to gradually upgrade in the state, and I think it will over a long period of time.

When the Medical Practice Act went into affect, did they grandfather in practitioners?

Everybody who was in Nevada. Right. That wouldn't have affected me. I had almost five years of training after medical school, but it would have affected a lot of people. They've made a lot of changes, of course, not just that one, but other changes over the years, that everybody gets grandfathered in on.

The Board would even be more visible if it weren't for the legal system that's set up in Nevada, because it's the legal system that keeps the Board from being able to carry through all the things that it does. The administrative hearings that we have are much more informative, much more information is obtained, and probably better judgement calls are made, than in any court system. Yet, as soon as anybody gets some type of a serious problem like losing their license, they nearly all go straight to the court systems, and eventually they get their license back.

That's something that's really relatively recent. You just don't see that sort of thing when you're looking back at the Board, for example in the 1950s and the 1960s, and really even the 1970s. It's much more prevalent now. Why, do you think?

I think our legal system needs to be overhauled so badly. We're in such disarray that it's just too big of a problem for anyone, even for the whole country to take on. Our legal system's in this bad of shape. I think that what they do is they take the easy way out, and the courts just give licenses back. It's much easier for the court just to give the license back because they accept no responsibility for

what that person does afterwards. They never even know what that person does. They don't follow-up, and could care less. It's much easier for them to give them the license because, otherwise, it's going to keep being referred to a higher court, and it'll just keep coming back.

What has happened is that, say, we take somebody's license away. Well, the first thing they're going to do is — of course, they already have an attorney, so they appeal it to the court system. Then they appeal it all the way to the Supreme Court if they don't get the answer they want. I would say that the majority, especially in Las Vegas, seemed to always get the answer they wanted in Las Vegas without having to go to the Supreme Court. The court systems frequently overrule our decisions to take licenses away. Sometimes even less punitive steps that have been taken are reversed.

The majority of things get referred to the court system, so we know that ahead of time. We know there's going to be challenge in the courts. Even taking all those precautions, it seems to amaze our legal counsels what happens in courts. It just amazes them that they can reverse some of the decisions that we make. I don't know how the court system really works. I know how it doesn't work, but I don't know how it really works.

With a recent appeal to the Supreme Court, the Minton case, the Board won.

Right. That's one bright spot. I think we made the right decision on the knowledge that was given before us. Higher authorities will have to make those decisions as to whether he gets his license back or not. The only trouble is that I wish you could make those people that give the licenses back that we take away, responsible for the conduct that occurs afterwards. There are some problems where

people can be retrained, but there's really no cure for certain types of behavioral problems. The only solution is to take them away from the situation.

Have there been cases where you see a physician again, maybe where you've taken a license away, it's been given back, and then there's been a further complaint because of behavior that's an on-going problem?

Yes. Even in the lesser behavior-type problems that we handle internally, that don't go to the courts, it seems like that there's a lot of the same names that are always popping up from year to year. This is one disadvantage of having term limits of eight years on the Board members. There's an advantage, too, because you can really get worn out in eight years and get in a rut, but the disadvantage will be that you won't have longevity. In the past, there have been people on the Board that have seen these people over and over again over a period of fifteen years, who really knew and understand an awful lot of the problems that they have. There won't be that continuity, and there won't be that history, in the future.

As soon as Ted Jacobs and Tom Scully leave, then the public member, Kathy Ebner — when those are off the Board, there won't be any long-term Board members. Nobody that will really remember the long-term history of the Board in relationship to what's happening. That'll be kind of sad in a way, but a new Board will still function. The eight years was plenty for me. I was happy to have the excuse not to have to go on and serve longer. The eight years was plenty.

What about the sense of responsibility that you have when you're weighing the decisions? If you're looking at taking away a physician's license, you're taking away his livelihood,

something that he's trained for years and years to do.

Right. You got to really weigh that. That always bothered me more than anything. All these hearings affected me in a very negative way to have to do some of things we have to do. I never liked it. I always hated it, but you have to do what the evidence shows, you know. If you're presented with a type of misconduct that requires your license to be removed, it needs to be removed. I could just see my own license being removed and what kind of effect it'd have on my life — it's sure not an easy thing to decide, and it always affected me. I was just drained after those types of hearings. I would try to forget everything as quick as I can, because it's just not a good, pleasant experience. That's why I say eight years is enough of that for me. I didn't enjoy that type of thing at all.

While you were on the Board, the Board hired and was sharing a lobbyist. One of the things evident over the years is an increasing involvement of the Board, or at least a more formalized involvement of the Board with the legislature.

Yes, the Board needs to have a close working relationship with the legislature. We didn't call him a lobbyist. I think we called him a consultant because the legislature didn't want him to be called a lobbyist.

The Board needs its autonomy. It does not receive any money from the state, it operates on fees that are generated from the physicians in the state, and P.A.'s. Mainly the physicians, and that's where all the money comes. It's all spent in Board activities for the public. You got to wear a different hat when you're on the Board than you would as a physician, because as a Board member, your main objective is to

protect the public. You're not there to protect physicians. You want to be fair, but you're not there to protect physicians. The legislature doesn't really understand the things that the Board's involved with without contact with somebody, like a consultant or lobbyist. They would just pass things that would make the Board nonfunctional. They just don't understand enough about it. There's nobody on the Board who could spend the time in the legislature trying to explain everything. The lobbyist or consultants that do this for a living know how to do that; they're already down there anyway. They've been very generous in recent years to the Board in what they charge. They've not charged us big amounts of money. Harvey Whittemore has been doing that for us for quite a few years; I was able to talk him into doing that when I was secretary-treasurer. We needed somebody, and he's been very, very good and very capable and has really helped the Board a lot over these past six years or so.

As secretary-treasurer you're head of the investigative committee. How did you see that function? Was that an interesting one? Was that a heart-breaker?

Well, it was interesting and scary at the same time, because you could easily get killed as secretary-treasurer. When I was secretary-treasurer, one of the people that we were taking a license away from was an elderly person out in one of the rural communities. He just happened to walk in the office, my office, one day. He told the receptionist he was Dr. So-and-so and wanted to see me. My office girls, of course, didn't know anything about any of this sort of stuff, and so he just walked in the room. If he had had a gun and wanted to, he could have just shot me right there. He figured that I was going to be the

cause of him losing his license. He didn't do that — thank goodness.

Was he threatening?

He didn't threaten me. He wanted to appeal to me to help him, you know. That was a sad situation. Even though he was elderly, he was not financially able to really stop working.

Where we have our meetings, there's nobody that's ever frisked or goes through any kind of detectors or anything like that. The chairman sits like me to you, in front of the person, and he's the interrogator. All the anger would be directed toward him if there's any anger. It would be easy to just pull out a gun and shoot whoever you wanted to shoot, because there's no protection at all. There's no security in any way. That's never happened, but I wouldn't be a bit surprised if someday something like that doesn't happen, because some of these people are very angry.

I felt threatened plenty of times, being in that position with no security in any way, especially down in Las Vegas, because there's real strange people that we had to confront. It was never — never nice. You make a lot of enemies, and you don't really make any friends.

As far as any of the physicians in the community realizing or caring what you're doing, it's very low profile. They are glad somebody's doing it, but they're glad they're not, and they don't really care about it, as long as somebody will do it. By being on the Board, it's not a place where you're going to get a lot of referrals or anything from other people because you're on the Board. But you're going to get a lot of referrals taken away from you by people who are angry about one thing or another.

What about intervening for physicians and substance abuse?

We do that mainly through the state Physician's Aid Committees. We have one in the north and one in the south, so we try to do it through that. The people who won't abide by the stipulations that they are requested to abide with, are turned over to the investigative committee. The investigative committee then uses its power to convince these people that they need to cooperate and get their substance abuses taken care of. Most of it can be done at that level, where it's not public knowledge. Occasionally, there will be people that just will flat refuse. They then have to be taken to the Board level and have actions taken against them. I know of one person who had his license taken away for a year to a year and a half before he finally conceded to seek treatment and help. Then he got his license back, and has done well, as far as I know, since that time.

That's where the Board comes in, so they really have gradually started working together — the Board and the investigative committee and the Physician's Aid Committee. When I was secretary-treasurer, unfortunately, I could not bring that about. I tried. I had lots of meetings with the powers-to-be and the Physician's Aid Committee, but they were so skeptical and afraid that the Board would do bad things that they just really wouldn't talk. It has evolved since that time, gradually evolved into a real cooperative effort between the Board and the Physician's Aid Committee.

One of the things that comes up periodically with the Board is the idea of forming some sort of an umbrella organization with medical examining. At one point while you were on the Board, there was discussion with the Board of Homeopathic Examiners about combining, and it was felt that there was a basic ideological difference. Virginia has an administrative-governing board that has representatives

from each health care board; California has a centralized board. Nevada has resisted this, but some believe that it might be the wave of the future. Do you think that's positive or negative? Or workable?

It may be the wave of the future, but I think it's going to have a negative impact on the Board of Medical Examiners. It takes away a lot of the resources of the Board, and they're really taking their money out of the Board of Medical Examiners to run all of the smaller boards. The physicians in the state, then, would have to carry most of the other boards and have to pay for it. I think that's going to be a disadvantage, because I think then you won't get your resources back to police the physicians in the state. That may be good for the bad physicians in the state. There aren't very many; to be honest, we're only talking about a small group. But to be able to find that small group is not easy, and it takes resources to do it. You're not going to have those resources when they spread them all around, because there won't be much money.

Most of the other boards hardly function. I think there's only about thirty homeopaths that I remember; most of the people that are homeopaths are on the board, or at least a third of them. So they don't really function properly. We would certainly not want to get involved in that, because that's a political thing.

The one with the most discussion was on the osteopaths joining in with our Board. There are about a hundred and some-odd osteopaths in the state. They really resisted any kind of association with our board, because they have very lax laws, if you read their requirements. They would have had to come in and adjust to our Board's stringent requirements for their new people coming in, and they've resisted it very much. They don't want to be under that type of an umbrella.

Their board doesn't function that much, either. Very rarely do you see anything about anything that's going on with their board; it's that small. They were operating out of Dr. McCurry's home for many, many, many years; they didn't have an office. They had very little money, so they didn't have investigators.

Since 1985, all of this for the Board of Examiners has just evolved: where we have investigators full-time. Our Board is just now getting big enough to evolve and have the financial capabilities of doing what it needs to do. If you put it under an umbrella, then it's going to take away that money and put it into running the other boards. The quality that the Board of Medical Examiners and the physicians are held to is above anything else, any of the other boards. Not even a comparison. The standards are much higher.

While you were on the Board, they issued a mission statement about working with other health care licensing boards and agencies to promote the protection of the public health, safety and welfare. Do you think the Board works effectively with other agencies and with other boards?

Well, it tries to, but I don't know that it always works effectively. The board of nursing and the board of pharmacy both do real good jobs. They're very active boards. We try to work with the other boards wherever we can, and especially with the board of nursing and the board of pharmacy, there's been a lot of cooperation. More so, I think over the last few years than earlier on.

It seems that part of the quality and higher standard you mentioned a minute ago is related to Continuing Medical Education. Physicians have tended to resist mandatory Continuing

Medical Education, preferring that it be voluntary. How do you feel about that?

Well, it didn't affect me one way or the other, so from a personal standpoint it didn't matter. I think, however, that the public wanted mandatory accounting of everybody. From that standpoint it's been a very positive thing for the public to know that everybody's required to have that education — that minimal educational requirement, that forty credits in the two years. I think we've made ours very workable, and it's working very well now. There were a few people that didn't comply early, but I think now everybody's complying pretty routinely without any problems.

Do you think it's a burden for some physicians?

It's got to be a burden for some physicians, especially the busy, rural practitioner, but they're probably the ones that need it the most. But it probably is a burden. They can't get it in their communities; they've got to go out of their communities for sure. If you really tried, you could get all of your CME hours in Reno just going to different meetings, without ever going out of town. In Las Vegas it's very easy.

To get really meaningful hours, you're going to have to take some trips, because that's not all going to be available in town. That's going to mean taking some time off. In the rural communities they don't have enough coverage, but they still need to get away: they need to get away, and they need to get some CMEs. So we feel like that the burden that it does create is a worthwhile burden.

CME credit has to be at least a credible thing. It can't be in scuba diving, and it can't be in flying kites or that sort of thing. It has to be in something meaningful to medicine,

and that is pretty much what everybody does. There may be always one or two people who do things that are not quite up to par, but nearly everybody does them in their specialty, or things that they need training in.

During your tenure on the Board, near the end, one issue was the discussion of the elimination of the oral exam. How did you feel about that issue?

Well, I don't know. I know it was a big inconvenience to have to meet with every single person. But I think it really did, at least, make everybody aware that there was a Board of Medical Examiners in the state of Nevada, and that they were pretty active. It's getting, however, to the point where you have so many licenses that are now being given each year that it gets harder and harder and harder to have those types of regular meetings. You still will have to meet with all the people who have any questions about their education, their conduct, their . . . anything that goes on will still meet with a full Board. The Board will still meet with ten or fifteen people every time they meet to go over all the details. Those full-board hearings take a fair amount of time; it'll still take a half a day or more for the Board to see just the full-board hearings. We've got enough testing that we weren't really turning anybody away. So now I think people won't have to worry about taking that little general test that we gave.

Can you tell me about an oral exam, as you remember it when you administered oral exams as the Board? How would it go?

Well, I remember we used to administer a very strict oral exam on the specialty. We had members of the community that would come out, two members of a specialty for a test of each person. We had a lot of people fail

those types of difficult specialty exams. We changed that because really we decided that nearly everybody was already board certified and had already passed all of that type of test. A lot of them weren't expecting such a difficult exam and weren't really that prepared for it.

So we changed it to a general exam, one that we felt anyone in any specialty should be able to answer. They were given for several factors: to be able to visualize a person and visualize his thought process, and to be able to tell how he responded under pressure situations as much as it was for the content. So we felt it served two purposes. We limited the testing to just the Board members and a few consultants, because we didn't have enough Board members to be able to get through the number of licensees that we had to examine in the time we had allotted. That worked out very well, except we found that nobody really was failing that type of test. I think this is the reason that they've decided to stop having those particular type of tests. That's fine with me; I don't see that that's a problem.

Did your time on the Board affect your view of the Board's function?

Oh, yes, because you had very little knowledge of what the Board really does, unless you're on it or participating. Yes, you really don't know what people on the Board do without being there and really being involved. You don't really know how much responsibility the Board has. I think that the Board members and the Board has conducted itself during my experience on the Board with total honesty. I think the physicians in the state would be extremely proud of the way the Board has handled itself. When a license was taken away, it was still done in a way that was totally honest and fair. The physicians involved had simply committed acts which were not acceptable.

You've been practicing medicine for twenty-six years? What do you think have been the most significant changes that you've seen in, one, the practice of medicine, and, two, the people who are coming into medicine?

Well, there's been tremendous change in the amount of technology that's in medicine. That's been the biggest change: the advances that have been made in technology, in all specialties. Just keeping up in your own specialty has been very difficult. I think that the quality of care has increased in every aspect of medicine in the cities. I can't answer about that in the rural areas, because I've not had any experience in rural areas that much, but in the cities it's just been a tremendous advancement.

The younger people that are coming out are extremely bright, dedicated people. There's a little difference in the work ethics among the younger group. They're smarter than the older group, and they try not to work quite as many hours. They try to manage their home life better than some of us were able to do. But I think that's all for the better.

What I'm worried about is the change that's going to occur over the next fifteen to twenty years. That concerns me because I'm going to be in the category that is probably going to need health care during those years. I think the tendency toward going back to a generalist taking care of everything and letting the insurance companies have total control over the health care system from doctor to patient to everything, to hospital, is going to be one that's going to be very detrimental to a lot of people.

The main other thing that I've noticed that's occurred that has had an adverse affect on medicine is the legal system — the unwillingness to allow physicians to be people and individuals and make mistakes.

Unless you are absolutely perfect, in our legal system you're a culprit. They've gotten totally out of hand, not just in medicine, but in every aspect of compensatory damages that are just way out of the ballpark from reality.

It can be something that the physician has no control over; it just happens. It's devastating to most physicians, and the legal complications take a tremendous amount of time away from what you should be doing. It's very detrimental to our medical practice, the way the system is set up.

Now, that doesn't mean that we should have carte blanche privileges to anything, everything we want and have all the complications that we want to have. But there should be some kind of definition, an established no-fault liability on certain aspects of things. Deliberate, injurious things are different than things that happen, you know, and happen to everybody.

So we should allow physicians to be human, to make a mistake.

That's right. Until society does that, they're going to hurt their own health care system. When these ridiculous awards are given, you know, somebody has to pay for it.

These are detrimental things to medicine; they're detrimental things to society. The legal system has made a lottery out of the medical system. In other words, some patients hope something will happen to them — although not life threatening — so that they can live on and collect all the millions. There are people that think that way in our society now because of what the legal system has done.

You mentioned technology as one of the most significant changes. Do you think technology has come between the physician and patient?

Well, I don't think it's come between them, but I think it has created expectations that are beyond delivery. Now they think with all the technology that everything should be able to be taken care of; that there should be answers to everything. And that's just not the way medicine is. If you're a surgeon of any type, you're going to have complications and you're going to have problems, and you're going to have things that you certainly wish would have never happened but that happen. There's really nothing that you can do about it, except try to be better the next time, even though you'll never be good enough. As a physician you're always trying to be better, and that's when I guess you say we're practicing. We practice till we die because we're never going to be good enough, and you're always trying to improve on whatever has happened in the past. But you're going to have complications that you got to deal with.

You said your grandfather thought you were foolish for going into medicine. You said, looking back, you're never too sure! [laughter]

Maybe that's right. [laughter]

Would you do it again?

Probably I would find an easier path to follow. I don't think that you need to bring that much of a burden upon oneself; there's too many other things. Knowing what I know today, there's too many other things that I could do and be very successful and happy, and not put near the amount of energy into. I'll have to admit there probably wouldn't be anything that would be more gratifying than what I've done on a personal level, so that part you can never reproduce.

Medicine's not an easy profession, and it's become much more difficult in recent years,

because as there is more technology, there are more complications, and there are more problems that occur, so that it does create other problems for you.

I made the right decision for myself, even though it wasn't easy for my wife and children, as it turns out. When I was younger and Jack Stapleton and I were together, we averaged sixty deliveries a month, and I would work as much as one hundred hours a week or more sometimes. I was always accusing Jack of trying to kill me, you know. It's a good thing I was at least six years younger than him, or he would have. But I survived those times and I'm smarter now.

I would never, never do that again. I guess when you're young, you think you have a lot to prove, but that wasn't a good way, a good experience, looking back.

How do you balance that commitment to medicine with your family and your commitment to a family?

Well, I always took medicine as first and my family second, and that was always a wrong decision. I changed that about ten years ago. I tried to put a more proper balance on it. It's easy because now I don't do obstetrics. So it's easy to have a family life and to practice medicine. But it wasn't the first ten years I was in practice. I put family second. I wouldn't do that again.

But family survived.

Family survived. They had some hard times, but they all survived. My wife's a very strong person, so she kept the family together, but if she hadn't been, the family wouldn't have survived. I was just there as a token father because I was beat by the time I got home. That's when the children were younger.

But they've all done well. My daughter is thirty now, and she's married to an obstetrician/gynecologist, Matt Barulich, in Carson City. She didn't learn much. [laughter] They live there and have two children, so we have two grandchildren.

My older son, the middle child, is twenty-seven, and he's an accountant with Felisini and Evans. He's married but no children. And my youngest son is twenty-three. He's still at UNR, and he's going to get a degree either in accounting or finance. He has another year or year and a half to go before he graduates. So they've all survived and done well, so far at least. But that's their mother's credit, not my credit. She's the one that has really kept the family together.

I've never really regretted what I've done. I've always enjoyed it. I was lucky that I was able to pick a specialty that I've been real happy with.

KIRK CAMMACK, M.D.

Dr. Kirk Cammack was born in Rock Springs, Wyoming, in 1927. He joined the navy at age seventeen and was a radioman in the Pacific near the end of World War II. He completed his high school education while in the navy, then received an undergraduate degree from Denver University and a medical degree from Colorado Medical School in 1953. He served a five-year surgical residency through the University of Michigan at Hurley Hospital in Flint, Michigan. He is a diplomate of the American Board of Surgery.

Dr. Cammack practiced in Boise, Idaho, for one year before relocating to Las Vegas, Nevada, in 1960. In the mid-1960s Dr. Cammack worked for three months in Vietnam through the auspices of the State Department. He has been active in both professional and community service activities, including appointments to the Nevada State Board of Medical Examiners from 1971 to 1981. He has published numerous articles in medical journals, including the American Journal of Surgery and the Rocky Mountain Medical Journal, and has presented papers at a variety of professional conferences.

Kirk Cammack, M.D.: I was born in Wyoming. My dad was a mining engineer, so we travelled quite a bit, but I was raised mostly in Colorado. My mother was a homemaker, and I have one sister, who still lives in Denver. My family had a Quaker background, and there was a focus on education and reading — that was a tradition with the whole family.

I went into the navy when I was seventeen. It was 1944, during World War II, and it seemed the patriotic thing to do. I wanted to get in and fight for the country. The navy wasn't a problem with the family; Quakers can accept pretty much anything, and they are not all passivists. I was in the Pacific at the end of the war as a radioman. I was frozen in the service for a period of time; they wouldn't let me out until after everybody else had gotten out, and then I came home and started school.

I went to the University of Denver pre-med and University of Colorado Medical school after getting out of the navy in 1945. I had quit high school. They had a system where you could get your high school diploma through the navy. I can't remember the name

of it now, but you graduated. I really started college when my classmates got out of high school.

Anita Watson: Did you always want to be a physician?

Yes. I don't know why. My mother always steered me in that direction, and that's what I wanted to do.

Was it a blow to her when you quit high school and went into the navy?

No, it didn't seem to be. If it was, she never remarked on it. My dad was afraid that I would get drafted into the army and end up on some invasion and get killed. So he didn't want me to go into the service, but he thought it would be better in the navy than to be in on some invasion like the Normandy beachhead or something. He was probably right.

A lot of students who were in medical school at the time must have been on the GI Bill. Did you have a wide variety of ages? Was it a diverse group?

Yes. There were all age groups, really. Some had been in the service for a long time, and some of us were short-timers. It was not near the collegiate atmosphere right after the war was over that it has been since then or before.

Did you enjoy medical school?

No, not really. Our class for some reason rubbed the professors wrong; they still talk about it. We had the poorest attitude and aggravated them more than anybody else. It was probably because of the war and being a little older than the other kids. It seemed to a

lot of us that they were trying to flunk us out. Nowadays they try to keep them in school, but at that time it seemed like they were after us. There were only eighty — there was like nine hundred applications and eighty positions. Because it was right after the war, a lot of people were trying to get in.

Surgery was your specialty. Did you choose that right away?

Pretty much. Initially, while I was in high school, I wanted to be a psychiatrist, but then after being on psychiatry in medical school, I could see that you couldn't see the results right away. That's when I decided to be a surgeon instead, because you could get the results pretty rapidly one way or the other. When I decided it was what I wanted to do, I went to Michigan for surgery training. I had a rotating internship, then I had a year of pathology, and then started surgery. I had my surgical residency at Hurley Hospital in Flint, Michigan.

Is it high stress? Do you have to be calm under fire?

Well, you have to have the personality for it. You train yourself to be calm under fire.

Where was your first practice?

In Boise, Idaho. When I finished my residency I went up there for a year with a surgical group. I was taking the second part of my board certification at UCLA and came through Las Vegas on my way back. There was only one board-certified surgeon here then, Dr. Kenneth Smith. There were other surgeons, but none was board certified, and a lot of surgeries were being done by family doctors. That was in 1960.

I decided to move down here and go into practice with a doctor that wasn't certified but that was doing surgery here, William Shaw. He had two offices, and when I came down here and went in practice with him, he went on a two-months vacation. Right after he came back he fired me. I think he just wanted me here to hold his practice until he came back, until he got a vacation.

And then what did you do?

Then I tried to start my own office. I didn't have any money, so I worked at an emergency room over at Southern Nevada Memorial Hospital. And then this family doctor, a great guy, let me use his office. His name was Bigford, Walter Bigford. He had a store-front office up at 4033 West Charleston, and he let me use it until I could get enough established to start my own office.

What was Las Vegas like in 1960?

The same as it is now only the tempo wasn't quite as good. It was a lot smaller, and I believe there were probably, I can't remember, sixty, eighty doctors, something like that here. Sunrise had just opened up. There wasn't any Valley or Desert Springs. It was just UMC and Sunrise, and Rose De Lima, of course, which was a small hospital barely making it. There'd been a bitter feud between the doctors at UMC. The ones that left UMC went to Sunrise, and there was a feud between two surgeons. That was about 1959, before I got here in 1960.

It was complicated; the feud was in relation to a number of patients and the way they were treated. The Las Vegas Sun had lots of articles about it in the paper. The feud culminated in about 1959 when Sunrise was built. Sunrise was financed mostly by money from the people at the Desert Inn.

That's an odd connection. I suppose it is a good thing to do with gambling money?

If you've got a lot of money that you don't want to declare, you can put it in a lot of places.

Was it done under the table or . . . ?

Well, I always had that suspicion. People came down here to help handle the Desert Inn money, and they had a lot of property around where the Sunrise was. It set out in the middle of nowhere then. There was no mall around it or anything like there is now.

Las Vegas was a big change from being raised in the mountains.

It was very exciting, though. That's what I was looking for, because there was something constantly going on and changes — just a constant turmoil — and people coming and going and interesting sorts of characters from everywhere in the United States. Some shady characters, a lot of shady characters.

Did you have any dealings with shady characters?

Oh, lots of them. Operating on them, gunshot wounds. A lot of people would come in with a roll of money in their pocket and pay you off in cash. And some of it would even smell mildewed. [laughter] They dug it up from someplace.

You mean they lifted it off of a body that had been at the bottom of a lake?

No. It was stuff they'd had put away, you know. A lot of them are dead now but one of them told me, "Say, Doc, this is graveyard. If

you repeat what I've told you, it's the graveyard for you."

Are you protected then by patient-doctor privilege?

I never had anybody question anything about what went on.

The mob connection is something that Nevada has always tried to distance itself from.

Well, lately, but then it was fairly obvious that the people, the money people involved, couldn't be distanced too much. They may have been in a way cleaner than they are now. It was called a safe area. The people involved didn't allow any crime to be done in the community. They kept it straight on their own. They didn't want any bad publicity here, or in Miami, which were the two places they called the safe areas.

So Las Vegas was an exciting place to be?

Yes, for a young man. We had three kids then; had four others after that. They all liked Las Vegas. I guess the kids during the Vietnam War didn't. The two boys were at the teenage stage. They didn't like anything. [laughter] One of them is still in Canada.

He moved there? How did you feel about that?

I told him I didn't think it was a good idea. I went to Vietnam as a volunteer to work with the civilians as a surgeon in 1965, 1966. I was there three months.

Can your son ever come back, or has he made a life for himself in Canada?

He could have come back any time. He never really got drafted. He was low on the

lottery bit. He got up there and liked it, and so he stayed. He's been going to college for fifteen years, I think, now. [laughter]

You went on the Board of Medical Examiners in 1971?

I can't remember for sure. It's when Mike O'Callaghan was governor; he appointed me to the Board. I knew O'Callaghan from being involved when he ran a juvenile home here, initially. I had one baby that was being mishandled by the parents and the foster parents, and I went to him about it. We talked, and there were hardly any juvenile facilities here at all. They had something like a cage to put the kids in out behind where the Board of Health is now. There were no facilities like they've got built up now. I went on the board of the juvenile home when the board was first established, and was on it until just last year when the legislature dissolved the juvenile board. It is called the probation committee now for some reason; I don't know why.

It was your interest in an abused child that . . .

Started it, yes. I was on it — I think it was seventeen years. They gave me a plaque; I don't know where it is. It's probably in the other room. [laughter]

Did you see changes over that period?

Oh, tremendous. There were no facilities at all when I first went on it and now there's a huge complex out on Bonanza Avenue. And they are building new complexes now. They have the family court now, which makes a big difference. Ruthie Deskin, the editor of the Las Vegas Sun, was on the board most of that time, too. She was very instrumental in getting all

of the publicity and what was needed to get the juvenile thing worked out.

What other public committees or public services have you been interested in?

I've been on the Board of Health for thirty years now, I think, and I am the oldest member. I joined the Board of Health in 1963, so I've been on that board for thirty-one years now. The County Board of Health does all the health facilities for Clark County, immunization of children, sewage — anything having to do with health facilities in Nevada. It's been very active and necessary, the way things have expanded in this town. Dr. Otto Ravenholt, he's been director of the Board of Health almost since its inception.

So you worked with juvenile problems, the Board of Health, the Board of Medical Examiners. Why have you been involved in these activities, given your busy schedule?

Well, there was a vacuum, and I just expanded into it. You could see there were things that needed to be done, and I just got involved in it, that's all. Maybe it's the Quaker background; I don't know. But it just seemed like something needed to be done, and it just happened. I never felt I had to do it; I just did it.

Governor O'Callaghan appointed you to the Board. Why did you want to be on the Board?

For the same reason as some of the other people who were interested in being on the Board. I didn't think they were the people I wanted on the Board, so I volunteered to do it. They weren't good practitioners; they weren't honest doctors in the community, in my opinion.

What about some of the issues during your time on the Board? There was some discussion in 1971 about the possibility of forming "a healing arts board." Later they used the phrase "an umbrella organization" to describe a Board of Medical Examiners for all health practitioners.

Well, we were kind of forced into that by the acupuncturists coming in, homeopaths, too. We were trying to develop some sort of control. The legislature was all behind these acupuncturist and Gerovital people. We were the only state in the nation where you could get Gerovital and they were taking acupuncture to the floor of the legislature.

You felt that was something that should come under control of the Board?

I thought it should be regulated — we were trying to get it under our auspices. I think I went up there and testified when that was going on.

What was your objection to acupuncturists?

It wasn't an objection; it was a matter of controlling it. I'd seen acupuncture in Vietnam, a lot of it. A lot of Moxi Buxon. That's where they burn an area on your back, or wherever they'd do it, with heat. I've seen a lot of people with disease neglected by using acupuncture and the Moxi Buxon. It was supposed to cure you. Certain areas of the body, like between the thumb and the little finger, have a nerve that goes to the head. All these various things, like acupuncture and Maxi Buxon, they claimed would help with the diseases.

You said that people who were being treated with these things were neglected?

Well, in Vietnam they were, yes. I operated on over forty ruptured appendices over there, and I don't think that maybe three or four of them had not had acupuncture first. I'm sure there's a place for acupuncture in pain control, but it's certainly not for ruptured appendices or for tuberculosis and many organic diseases that they claim cure for.

During the time that you were on the Board there were a number of incidents with the physician named Samuel McCarran. Do you recall Dr. McCarran?

Yes. I don't know how much to bring up. He was Pat McCarran's son. McCarran was our senator for many years, and McCarran Airport is named after him. He was very powerful in Washington. He had the McCarran Act that placed a restriction on all foreign immigration at one time except for the Basques. He let the Basques come in to do the sheepherding.

His son was a doctor. And he was an alcoholic. They had trouble with him before I got on the Board. They sent him — I forgot the little town in Nevada — he would stay there, you know, because he was Pat McCarran's son.

He was in Eureka for a while.

Eureka, that was it, yes. He had problems wherever he went.

Was that a ticklish situation for the Board, do you think?

Well, a lot of it was run pretty much by the seat of the pants of Ken Maclean. He's the one that knew Sam McCarran and Pat McCarran. They just tried to do the best they could with him, but he just kept fouling up. I don't know whatever happened to him.

Then there was a gynecologist whose name I can't remember who was in Carson City. We had a hearing to take his license in Carson City. His nurse came in before he came in and said that he had a gun in his briefcase.

Was that Dr. Moore? There was a physician who was led out of a hearing in handcuffs.

That was him. His nurse came in and said he had a gun, so then he came in right behind her, strolled in with his briefcase. He was a real maniac. Dr. Maclean knew him, and he took him out of the room, where he got him to leave the brief case in the other room. We opened the briefcase. There wasn't any gun in it, so I don't know if he had a gun hidden. We didn't know if he had a gun hidden out in the hallway or where it was, but he had a briefcase full of amphetamines. [laughter]

We tried to get someone to arrest him because he was unmanageable. We had to call the district attorney, and he wouldn't do it without observing. So he came down and stood at the back of the room and listened to the guy, and then he finally said, "OK, that's it." That's when they handcuffed him and took him off. He threatened to kill the members of the Board, particularly the doctor in Carson City, a family doctor, Dr. Grundy. It was particularly Grundy he was going to kill.

His attorney said, "We didn't finish the hearing." He's an attorney in Carson City, has a long Italian name, very dramatic. He said, "We didn't finish the hearings, so actually you may have his license, but the hearing wasn't completed, so he could still legally practice." That was his dodge around the whole thing.

Moore was arrested and taken out but in handcuffs. They took him to Sparks and incarcerated him. Our attorney, Bryce Rhodes, called up there Monday or Tuesday and they had already let him go and hadn't

warned us that he was gone, you know. And so Grundy left town. [laughter] We all made ourselves scarce until we found out where he was. As I recall, he showed up in Elko at Dr. Moren's house. And Moren tried to reason with him, and he went berserk up there again. I don't know what happened to him after that.

One of the issues during your tenure on the Board was about requirements for Continuing Medical Education. The Nevada State Medical Association did a survey, and the majority of physicians who responded were against mandatory Continuing Medical Education. Why do you think that is?

Because they didn't want it mandatory and having some bureaucrat deciding who should do it — that was the main reason. They didn't want a bureau telling them that they had to do it. But we had a hassle with the doctor in Lovelock who hadn't been to any postgraduate education since he had gone to Lovelock, where he practiced for thirty or forty years. He had practiced his heart out up there, but he was just so far behind on everything. Half the town loved him, and half the town wanted him out.

We had a hearing on him; first in Lovelock and then in Reno. And we had people walking with signs outside of the Board hearing. He had refused to come see some kid who was sick, and the rancher father kicked down the door of his house and forced him out to see him. The old guy was just so tired and fatigued that he really shouldn't have been practicing. We took his license, finally, after four days of hearings. He went back to Lovelock, and the next day the judge gave it back to him. The Board of Medical Examiners lifted his license, but the judge ordered it back.

How did you feel about that?

That was the way a lot of the things went. We had no real legal clout, or at least it wasn't used like it's been developed since then. We had a doctor here in town that handed out seven thousand prescriptions in one twenty-four/forty-eight-hour period. The Bureau of Pharmacy had a camera set outside of his office taking photographs of all these people going in and out. We sent people in there to witness — he had a table set up with a stack of prescriptions that they would be handed out as they were handed the money. We had movies of a young kid walking in there and being carried out. And still we were unable to get his license. We took his narcotic license, and he had some clout back in Washington, and he got it back within a short period of time. We were unable to get his license because of various political maneuvers.

So that's frustrating? You could feel yourself caught in the bureaucratic quagmire?

Yeah, but it was Nevada politics at that time. I don't think it could happen now. I hope not! I think Ted Jacobs did a lot in his tenure there to get some clout with the Board and get it a lot more than just a facade when it came to really disciplining doctors.

But the legislature was passing acupuncture, homeopath, Gerovital, all these marginal medical things, despite any testimony that the Board would give them; they passed it anyway. A lot of people were investing in the stock in the H3 or Gerovital thing. It's procaine which is what the dentist gives you when you have your teeth frozen. It's mobilized through the liver within less than a minute, and it's out of your system.

You were talking earlier about being stymied by politics. Did it seem to have been inevitable that the Board would begin lobbying efforts?

Well, we didn't ever get anything done with the legal counsel we had, I thought. It was Bryce Rhodes. He wasn't full time. He was a good old boy, particularly Ken Maclean and Rhodes. And they had a definite bias against the southern end of the state, too. Ken Maclean used to say, "OK. We'll give him a license if he promises to stay down in southern Nevada."

Was there divisiveness on the Board because of the north south split?

I don't know if it was divisiveness or not. It was pretty obvious that they had a real — I mean it's Maclean who kind of ran things with the Board. They had a real bias against the south.

Over ten years on the Board you saw a lot of change. What do you think was the most significant or the most important change for the Board in that ten-year period? Possibly the most important tasks they performed?

Well, just gradually getting a more — what's the word I want to use? Getting the rights established for the changes that came later I think was the thing. There were so many different things going on that had eventually to be changed and eventually were changed. It was a gradual process at the time I was on.

So it was preparation?

Yes.

What do you think the Board's most important function is?

Discipline of the physicians, I think.

And now you feel there's some teeth in what they're doing?

Yes.

It's been said that the Board is important as a preventative entity because of the possibilities of discipline, as a factor in keeping people on the straight and narrow.

There were a lot of people that would be in trouble in California or someplace else in the nation — people that thought they could get away with coming to Las Vegas or coming to Reno, coming to Nevada, and would come for licensure. Most of them we found, but the problem was there was some exotic things.

Like we had one young, clean-cut-looking man from Loma Linda who you think would be straight and narrow, but had a male child prostitution thing going in California. He was renting Rolls Royces and Mercedes, and stealing them. He had all sorts of rackets going in California that we found out about through sheriff's checks and things like that. Some of them got through that we didn't find out about. And if they already got their license, you couldn't revoke it.

I wanted to get a law passed that you did a license for a year or something, and then have it renewed if you were straight for a year, you know. But I guess according to our legal counsel it was not possible. You either got the license, or you didn't. Apparently one of the hardest things you do legally is to deprive someone of their occupation, or their way to make a living.

The Board got criticized a lot for not disciplining people. And most of the reason you couldn't discipline them is because the attorneys would get into it and prevent us from doing disciplinary action. Like Dr.

Moore from Carson City. He had a very good lawyer. And he delayed and prolonged everything even to the time we had him hauled away; he kept saying, "But you still haven't had a total hearing."

The practice of medicine has undergone some significant changes in the period that you've been in medicine. And some people would say that they have lost the individualism of the physician. What do you think about that?

Well, I think that's true; there's no question about that. And that's the way of the future, too, I guess. We have the gatekeeper. That's why I was delayed here today, because a kid's got a rare type of hernia and they couldn't find it in their computer to classify it, so they didn't know whether they were going to OK it or not. I finally got through to some surgeon that knew what I was talking about.

To a certain extent you could interpret it that the insurance companies have taken over some of the functions of the Board of Medical Examiners by refusing to give insurance in certain cases. For example, not permitting general practitioners to do OB/GYN.

Yeah. They're doing it. I'm not sure it's all for the better but some of it's for the better. You said OB/GYN — we've had some pretty bad situations with some gynecologists. People refused to give them malpractice insurance anymore. I don't know what they're going to do in a rural situation, because no one can afford obstetrical insurance in a family practice like that, you know. You're still liable for the child until he's twenty-one.

I met one doctor who had a situation where the kid flunked his college pre-admission. And he went back and sued the

doctor from when he was born; he said he had some brain damage; that's the reason he flunked. [laughter] I don't know what the results of the suit were but that's what the suit was about.

Certainly litigation has had tremendous impact on the practice of medicine.

Dr. Jacobs and I got sued for eight million dollars because we couldn't find anything wrong with this patient.

When was that?

That was before he came on the Board. I was on the Board, and the patient claimed he had bad varicose veins. Which obviously he's got them or he doesn't. Neither one of us could see them, and we wrote a letter to that effect. He sued and he was his own lawyer. It went on for a year, and we were on the stand for hours.

Was the case eventually dismissed?

Yes.

Did you enjoy your time on the Board?

Well, I always said it would make a good TV program.

Would it be a comedy or a drama or soap opera?

It could be everything like that. Part of it was comedy; part of it was drama. Just the personalities on the Board were interesting, too. Ken Maclean was a tremendously interesting curmudgeon. He was the senior surgeon of Nevada. His dad had been a surgeon before that.

Who else do you remember on the Board?

Les Moren and Grundy. Jacobs came on near the end of my tenure. Dr. Zucker, Reuben Zucker. I don't know what he did, but, anyway, O'Callaghan got mad at him. I know one thing, he was trying to get me kicked off the Board for some reason I never did know — Zucker was. But then O'Callaghan had Zucker taken off the Board, but he wanted a Jewish member on the Board. Zucker was Jewish, and he wanted to replace him with a Jewish member of the Board.

That's when I talked to Ted Jacobs, and his wife said, "No, he's got enough to do. He's not going to" But finally he agreed to do it, fortunately for the State of Nevada, because he has done a tremendous job.

Eva Simmons was one of the first women on the Board. She's a very active mind. I was on the juvenile board with her for a long time.

Do you think the Board should be politically appointed?

Yes, I think so. I don't know exactly why; I don't know how else you would get a balance throughout the state without doing it that way.

It seems some people manage to overcome the politics. Certainly with Dr. Jacobs; appointed and reappointed by a variety of politicians and parties. Do you think the Board should be above politics?

There's not much that's above politics.

Generally your experience on the Board was positive?

Very interesting, very educational; I grew up, [laughter] lost my naivete. That idealistic approach to your fellow physicians, you

certainly lose that on the Board of Medical Examiners. At least at that time we did, and they probably still do.

People tend to put physicians on a pedestal. Do you think other physicians do that with each other to a certain extent? Do you think you expect more of them than you do of other people?

Yeah, I do. I don't know how many do, but it depends upon how you are brought up, I guess. Dr. Verbrughen, he was the first neurosurgeon in the southern part of the state, he and Ernie Mack up north. Dr. Verbrughen used to say that an honorable physician is raised at his mother's knee. Either you are or not, but it's before you get to medical school that it happens. I'm not being sanctimonious, but it's true.

ANTHONY CARTER, M.D.

Dr. Anthony Carter was born in New York City in 1930 and lived on Long Island until his family relocated to the South during the Second World War. He attended St. Stanislaus School in Mississippi for junior and senior high school, then Loyola University in New Orleans, receiving a Bachelor of Science degree in Biology and Chemistry in 1951.

He continued his education at Louisiana State University School of Medicine, graduating with an M.D. in 1955. He did a general rotating internship at Charity Hospital in New Orleans, then fulfilled his military obligation with the U.S. Army Medical Corps in La Rochelle, France, from 1956 to 1959. He returned to Charity Hospital for a pediatric residency from 1959 to 1961.

Dr. Carter relocated to Las Vegas in 1961, where he became one of the first two full-time emergency room physicians in Nevada at Southern Nevada Memorial Hospital. He established a private pediatric practice within a year of moving to Las Vegas, and remained in private practice until 1982. That year he entered a multispecialty group practice with

Southwest Medical Associates, where he is presently active.

Dr. Carter is Pediatric Board certified and the director of the Medical Consultant Program for learning disorders at the Dorothy Siegel Diagnostic Center. He has been active in medical politics, serving as chief of staff for Southern Nevada Memorial Hospital and as medical director for Southwest Medical Associates. He was appointed to the Board of Medical Examiners in 1980 and served there for eight years. During his tenure on the Board he served as vice-president for four years, and on the investigative committee for three years.

Anthony Carter, M.D.: I was born in New York City, and I lived the first ten years of my life in a small town on Long Island called Merrick. Now it's contiguous with New York City, but at that time it was kind of a country town with four or five thousand people, surrounded by farm land. I have three brothers; we are very close in age, three years from top to bottom.

In 1940 my father went into the service, as many people did in those years, and the family moved south to be with my father's in-laws. We spent a year in Shreveport, Louisiana, and then we moved to New Orleans.

Anita Watson: What did your father do when he wasn't in the military?

He was a family practitioner. He graduated from Tulane in 1923. He practiced in Long Island until 1980 with the exception of the years he spent in the service, which was 1940 to 1947.

And what about your mother?

My mother has been involved in medical transcriptions for a number of years. She worked at both Sunrise and Southern Nevada Memorial Hospital, and then corrected transcriptions and stuff for a number of years. She died in 1982.

You mentioned the family connection to Louisiana. How did your father end up in Long Island?

That's where my mother was then. He followed her to Long Island. She had moved there about a year before.

My brothers and I were educated at St. Stanislaus, a Sacred Heart Brothers boarding school in Mississippi. We all three graduated from that particular school. My older brother went to Loyola in New Orleans for a year, and then went to seminary and became a Jesuit priest. He's now president of Loyola. My younger brother attended Loyola a year behind me, and went to St. Louis University School of Medicine. He's now a gastroenterologist residing in St. Louis.

Why boarding school?

Many people did in those days because there was a war going on, and most of the fathers were gone. Anybody that had teenage boys found that it was much better for them to be in a structured environment than to be in an unstructured environment. So the boarding school was very popular at that time.

How old were you when you went?

I started in the seventh grade. I was eleven, and I stayed in that environment for six years: two years of grade school, and then four years of high school.

What about the difficulty of leaving home?

Well, it really wasn't there. We really didn't have a home per se, because my father was gone. My mother was working full time, and so we almost didn't have a home. School became a surrogate home for us.

Boarding school is kind of a unique experience. Of course, if you hadn't ever been around it, by today's standards it would seem rather bizarre. It would be comparable to being in basic training, but the discipline was not so much like the army where you had to parade around and stuff like that. I guess the thing that makes it seem bizarre by today's standards is the lack of privacy that one has in that kind of a situation. Your days were extremely regimented. For instance, we were required to stay on the campus twenty-four hours a day with the exception of structured town leave on Thursday and Sunday. We went downtown to the movies twice a week in a group.

It was very structured. It would have to be dealing with all kinds of people. Everybody got up at the same time, and everybody was responsible for taking care of their bed and their own clothing. School was started when

the bell rang; everybody was in place and ready to go.

Boarding school was not really a hardship. It was good fun, and it was very conducive to studying. The school was an exemplary level of education — 85 percent college graduates from this particular school. It was just a very fine situation.

The brothers were very dedicated, and it was business-like. They were smart enough to have virtually the entire student body involved in violent athletics.

Violent?

For teenage boys, that's what you need to do. We had rather outstanding athletic teams in virtually every endeavor. Just for instance, this may not mean anything to most people, but we played triple-A football with a student body of under three hundred. Most triple-A schools run between thirty-five hundred and five thousand students. [laughter] And we were playing in that league with three hundred.

Most of the boys in school, then, were focused on football?

Focused on athletics, but as I say, that never came before academics. It was very well balanced, a very healthy environment, I think, for teenage males. I don't know if you could call it a model by today's standards, but it certainly worked in that time.

The academics were important. We were doing things in chemistry and physics that one wouldn't ordinarily see until the second year of college. It was very advanced. The English program was extraordinary. In those days they didn't have too many comprehensive tests to measure one school against another, but I do recall that one of the navy programs was

testing all the seniors (this would have been in 1943), who were desirous of going into naval aviation for that given year. They were trying to pick off the best students. The principal of the school was shocked to get a call from the Navy Department: my brother had scored second in the country. [laughter] We thought that was a good indicator that we were getting a pretty good education [laughter] in this little tiny school. Everybody who wanted to go to college did and succeeded. I went to Loyola, graduated in 1951. We were very well prepared for a college experience. There were four or five doctors in my class of sixty.

Did the school funnel you into Loyola?

No. My brother was already there, in Jesuit training. He went there for a year, and then he became what they call a seminarian, which means studying to be a priest. We all would naturally head towards the Catholic college in New Orleans.

You wouldn't go to a non-Catholic university unless they had a program that they didn't have in the Catholic school. In other words, if you wanted to go to medical school and they didn't have a medical school, well, you obviously couldn't go to a Catholic medical school. But basically the tradition was, at that time, that you stayed in track. There was nobody forcing you to do it, but that was what most people did. They were comfortable with the environment, with the philosophies, and so forth. It made breaking through the barrier from high school to college easier. You were dealing with religious people who were in education for other reasons than you might see in some secular schools.

It sounds as if there was an emphasis in your family on academics.

Well, I think that's a tradition of that era in our history. I don't think it was particularly peculiar to my family. I think most people were of a mind that your chances of becoming a successful and effective person were intimately associated with your educational experience. Somehow that seems to have gotten lost [laughter] in the culture, but nobody seemed to have a problem with it.

The flip side of that is that there was also at the time the draft. Many people stayed in the educational track because they avoided going in the army. So I don't think that was really a factor as far as I was concerned, but the fact is that a lot of people were in college because it was a better choice than going into the army. I can't remember the year conscription ended, but it was well past the time I was in college and in medical school. It went on into Vietnam and so forth. So people would often take the academic track to avoid military service.

You majored in biology and chemistry. Being raised with a father who was in medicine — did you always know that was what you wanted to do?

Not particularly. I changed my career goals a couple of times. I thought I would do different things, go into advertising, or something like that. But I really hadn't nailed it down until I graduated from high school.

By the time I registered for college, I had made at least the mental commitment that that was what I wanted to do, so I registered in pre-med. I had entertained other possibilities prior to graduation from high school, but once I decided to go to college, the decision was made, and that was before I started college.

You went directly then to Louisiana State University and entered your medical program there. What was medical school like?

The LSU medical school is actually in New Orleans, and the main campus is in Baton Rouge, ninety miles away. That's a great big, huge campus with a lot of diverse things going on. I think there are like twenty-five or fifty thousand students up there. But the medical school was in downtown New Orleans. The difference between going to college and going to medical school was just a question of another twenty minutes on the street car. I just went further downtown, and the courses were a little more intense in focus, but just more of the same thing for another four years.

One of the constants, in talking to physicians, is that medical school was hard work.

Well, it wasn't. The hard part is being focused. You're at an age and a time in life when most people are busy being productive — having a family, children, and so forth. You have the idea that those are the years when you really want to start getting things done. The hard part is just having the patience to focus on the things that you have to learn. You are the age where you're getting antsy, and it seems like you've been in school forever. I feel very fortunate with the background both in high school and college for the type of things that I had to do. I didn't find medicine all that difficult. It was more time consuming, and a test of patience and endurance than it was rocket science.

You graduated from LSU in 1955, then did a one-year, general, rotating internship. How does that work?

Well, that means that you rotate through all the services. In the present day, when you finish medical school, you can intern in a given specialty. For instance, I could take an internship in pediatrics. In those days

everybody took a general rotating internship, almost without exception. Those internships included two months on surgery, two months on OB/GYN, two months in pediatrics, two months in medicine, a month in an emergency room, and a month in anesthesia or something comparable. It broke up the year to give you hands-on experience in those specialties. In my particular case, because of the nature of the hospital, it was not only hands-on, but hands-on in large numbers. You had a very, very physically tough, tough year. Of course, mentally it was challenging as well. There was just so much work to be done, and it was very difficult. That was big-time hard work.

What would a day have been like?

Well, in surgery the day might begin as early as 5:30 or 6:00, if you got to sleep at all. I remember in most cases I would go to late supper, which was 11:30 or 11:45. Oftentimes I'd hit the 2:30 a.m. mini late supper, indicating that I was awake. I wouldn't have gone to those places if I wasn't busy. I was up and doing things, attending to the emergency room, and then attending to the ward patients, and doing emergency surgery and so forth. It was not uncommon in surgery, for instance, to be doing a twenty-hour day, four to six days at a time, and then have one day off. It was physically very tiring. Of course, when you're twenty-five years old, it's a little easier.

You saw a variety of patients?

Everything.

Any of them stick in your mind?

Well, when you cover the range from trauma to obstetrics and everything in

between, it's just a sheer mass of people that you end up caring for over a period of twelve months that you remember. You face an incredible experience physically, very tiring, but, at least from a physician's standpoint, it's a wealth of training, about ten years experience in one year. So it's a very fruitful year. I would certainly not like to do it again. I'm not physically able to do it again, but it was the way most were training in those days. And it was brutal.

Did you have any indication in medical school of what you wanted to specialize in, or were you going into the rotating internship with an open mind?

I didn't decide until after, because I went in the army after the internship. But I was entertaining a specialty in general surgery or pediatrics, one of the two.

You went into the army. Was this something that you delayed because of the school and you then had to fulfill?

In those days everybody had an obligation to serve in the military. I was exempt from the draft to go to medical school and became what they called the obligated volunteer. This meant that upon your graduation from medical school, you had the option of joining the army and becoming an officer, or being drafted in the army and becoming a private. Most people chose to become an officer, and so they were obligated volunteers. I went immediately after my internship. Partially that was because I really wasn't sure what direction I wanted to go, and it was a good time to get that obligation out of the way.

You spent a couple of years in France. Were you treating dependents?

I was at a small army base that supported the transportation corps battalion. All doctors are called surgeons in the army, so I wasn't a surgeon, but I was a battalion surgeon for this transportation corps battalion. I was the only doctor in the battalion, and I was the only doctor on the post. I treated not only the military personnel, but also any dependents that happened to be there at the time.

During the latter part of my time in France I was transferred to a larger hospital, the last six or eight months. In those months I was exclusively doing pediatrics, because they had a vacancy and they needed somebody to do that. I worked under a very outstanding pediatrician.

Was working under this pediatrician a motivation for your choice of specialty?

Well, it was partially involved in the decision. But, also, it had become very clear during my internship and when I worked in the hospital ward in France that a lot of doctors were really not good at pediatrics. It was like they were unable to apply the knowledge that they had because the children scared them so much. It never seemed to be a problem for me. It's like any other field of endeavor: some things come natural to you and some do not. Seeing that this was a very easy thing for me was part of the decision process.

What is unique about pediatrics as opposed to other specialties, other than the fact that you're working with small people?

Well, I think the most satisfying thing about pediatrics is that everybody gets well as opposed to adult medicine, where your patients all get older and sicker every day. In pediatrics they get older, but they're not

getting sicker. In pediatrics the illnesses are short, by and large. I prefer when problems come to close quickly, and that's what pediatrics is like.

Some children do have terminal illnesses and serious illnesses.

Right. But it's very few, and usually, at least in the last fifteen years or so, by the time we've clearly defined an issue that's fatal, they're in the hands of another physician. So we don't have to deal directly with that acceptance, with supporting the family. We don't really manage leukemias. Almost every community has somebody trained in pediatric hematology. They do that better than you could, so they do it. We usually stay on the case, you know, just for the family for supportive care. That takes a lot of the stress of a long-term patient away from general pediatrics. General pediatrics is getting much easier as time goes by because of specialties, which take out all the big headaches.

After you left the army, you came back to Charity Hospital for a two-year residency. How did the residency differ from the internship?

Well, it wasn't physically as hard, and you were focused, of course, on one subject. So it wasn't as intellectually challenging, because you could kind of relax. You didn't have to learn about problems that one encounters in the adult population; you could focus on the things that you encounter in pediatrics. It made that part of it easier. And, of course, the whole reason for specialists altogether is that the doctor isn't required to know everything there is to know about everything in medicine — which nobody could possibly do.

After you finished your residency in 1961, you came to Las Vegas. What prompted you to come to Las Vegas?

A friend who was personal friends with the administrator of Southern Nevada Memorial Hospital. He was looking to staff his emergency room with full-time physicians.

You did your residency in pediatrics, but you went into emergency room work?

Right. In those days there was no such thing as an emergency room physician. People who staffed the emergency rooms, and there were very few, were people who had the same basic medical training that everyone else had. It just isn't comparable to an emergency room physician today. The army uses the phrase "general medical officer," which means you are a trained physician without a specialty. And that's the kind of people who staffed emergency rooms in those days: people who had graduated from medical school, who were trained in a rotating internship, and who were capable of treating adults and children and so forth.

Just because you had two years special training in pediatrics doesn't mean that you didn't know anything about treating adults. You had already been trained for that previously, especially when you've trained at Charity Hospital, which probably prepares somebody for emergency room as well as any place in the country. It's only twenty years ago or so that the actual program was developed to train people exclusively with emergency room medicine as a separate subspecialty. There was no such specialty in the early 1960s.

How do you go about setting up an emergency room?

Well, I didn't set it up. All medium-sized or small hospitals had emergency rooms. They had rooms in the hospital with emergency equipment, and they were staffed by nurses. The physicians in general would rotate on call to the emergency room. That's exactly what was going on in Las Vegas and Reno, I think.

So at the time hospitals all had emergency rooms, but did not have physicians physically present in those emergency rooms twenty-four hours a day. That was the innovation that Mr. Staggs wanted to bring to Southern Nevada Memorial Hospital: to put salaried physicians in the emergency room rather than having physicians on call. That would prevent the situation where somebody with an accident comes into the emergency room in the hope that the person who's on call is available, number one, and number two, that he shows up.

You have to understand, an emergency room in those days has no resemblance of any kind to the emergency rooms as we know them today. Emergency rooms in those days were not used for any kind of primary care; they were used for only the most severe injuries and the most acute medical emergencies. If emergency rooms were used today like they were used in those days, they'd have to close about three quarters of them, because what they're doing today is after hours practice. And we are throwing in a little emergency medicine on top of it.

Was the emergency room stint always intended to be temporary?

Oh, yes.

Then you went into private practice. Did you go into practice by yourself?

Yes. I was in practice basically by myself until 1982. I had partners along the way. Dr.

Thomas Scully joined me for a year in 1966, I officed with Dr. Charles Snaveley for about eight years, and then I officed with Dr. Beverly Neyland for about five years during the time I was in private practice.

Las Vegas is an interesting change from the South and from Louisiana. What was it about Las Vegas that appealed to you?

Oh, I think a couple of things. The first was that New Orleans was just overcrowded with doctors by virtue of the fact that they had two medical schools. And I was anxious to move west. I was interested in skiing. I like the low humidity and the clean air that we used to have.

Las Vegas at that time was right at about one hundred thousand people, and, as you know, today it's very close to a million. So it was just really starting to boom at that time. They were obviously anxious to have more physicians. I think there were seventy members of the Medical Society the first meeting I went to.

What were some of the problems or unique situations that you faced in setting up in private practice?

Well, initially there were no pediatric subspecialties, of course. Being in pediatric private practice in a relatively small town meant that you had to do the premature care and the in-house hospital care, and a lot of intensive type of medicine that is now being done by people who are permanently employed in the hospital. Neonatologists, of course, don't do anything else but work in a hospital, and the pediatric intensivists don't do anything else but work in the hospital. Emergency room doctors are there, and that's all they do.

Well, in those days we basically had to do all that for ourselves. So not only were we doing a basic general pediatric practice, but we also did a little emergency room medicine, a little neonatal care, and a touch of specialty medicine that you would like to have referred to somebody with more knowledge and experience. Those people just didn't happen to be available unless somebody was willing to get in the car and drive to Los Angeles or Salt Lake City. There were very few subspecialists, and we basically had to do it all.

What do you think are the most significant advantages with specialization?

Well, just in that you don't have to learn the entire dictionary. You only have to learn what's under "P," as in "pediatrics." That's a whole lot easier than learning the whole alphabet.

You mentioned pediatric subspecialties.

There are different subspecialties such as pediatric ophthalmology, pediatric cardiology, and so forth. They have become so very scientific and technologically oriented that a private general practitioner of pediatrics would have a problem keeping up with those fields. It's an actual evolution when those problems became so specific, and people have intensified their educational background to accommodate those problems.

That's how the different specialties developed, where they came from: in answer to existing problems. Just exactly like the emergency room, it became clear about the early 1960s that the private physicians could not or would not be able to manage the twenty-four-hour care that the people were demanding. This created a void, and this void was filled by developing hospital emergency

rooms, and a staff of hospital emergency room specialists to manage those things.

Do you think there are drawbacks to having subspecialties?

Well, the obvious drawback is, of course, that a lot of people are so specialized and so focused that they can't see the wood for the trees. That is a problem. It also encourages the use of technology to a fault. I think the inappropriate use of technology, surgery, or whatever has been part of the cost problem that we are encountering today.

You went into group practice after all these years of private practice. Why was that?

Well, a number of reasons. The first was that my very good friend formed a group. He invited me three times and on the third go-around, I said I would. The issue was that the private practice of medicine was starting to become a little more difficult. The day-to-day management of a medical practice is certainly not any fun after the first couple of years. So to have somebody take over the headache of hiring help and monitoring help, and to take care of financial matters and to do the billing, just the business of medicine, was a great relief. It was in the very beginning of the transition we're seeing now where most of the doctors who graduate from medical school today plan on being in a group. Almost nobody plans on being in private, solo practice, which is exactly the opposite of when I graduated from medical school. A couple of my classmates did join large prestigious groups in New Orleans, but other than that 90 percent of the people were headed towards private, solo practice or a small group practice.

Is it possible to be in solo private practice today? Is it practical?

It's not terribly practical; it's certainly possible. It's very hard work unless you have some type of coverage because it's, of course, impossible for a person to be available, especially in the primary care area, for twenty-four hours a day for three hundred and sixty-five days a year.

The hard part is not the difficulty of work or the volume of the work; it's the timing of the work. A person who can do a very credible job and work an eight- or ten-hour day may not be able to do so if he's summoned to the emergency room at three o'clock every night for about a week for various things. That's what makes it difficult. The actual work and the volume of the work is not that big a deal. It's the taking you away from the dinner table and your family and stuff like that. That's what makes it hard.

Physicians did that fifty years ago, sixty years ago. What's changed?

I think patients are less considerate of their physicians in that they'll call for very trivial things at two o'clock in the morning. Whereas fifty years ago, when my father had a very large practice, I remember very well him responding to emergencies and such as that, but it was very, very rare to have a midnight telephone call or a late night telephone call. My understanding is that in those days people just didn't do that.

What has changed that they do that now, do you think?

Well, I think it's a combination. People want what they want now. In addition, the work day is different now than it was fifty years ago. Fifty years ago you couldn't get a meal in Fort Worth after eight o'clock. There was nothing happening. People worked from

eight to five or nine to five or seven to six. Then they went home and had dinner and went to bed. Of course, now the economy is different. Things are going on twenty-four hours a day, so your services need to respond to that. The only way you could do that is to be in a group. You can't respond to that type of twenty-four-hour operation as a solo practitioner. It just doesn't fit.

Las Vegas is a good model because we were ahead of the country with a twenty-four town business. Now virtually every large city in the country is a twenty-four town. Some are people who are working, and some are people who are not working, but they are still up and about. The issue is that the demand for service has increased dramatically, not in volume but in the type of services that they want. Most people fifty years ago, I think, went to the doctor when they thought they were going to die, not when they were sick. [laughter]

Preventive medicine, however, is a good part of your practice?

Right. The whole concept of pediatrics is, of course, to prevent illnesses rather than treat them after they happen. All of the initiatives and the science that was done in the 1920s and 1930s developed the vaccines that we use today. It's probably one of the most outstanding areas of medicine, not only in effectiveness but certainly in cost effectiveness. It's a model for other changes in that the things that we've done have cost very little money and are very, very effective. And saved untold millions of lives, and made them meaningful ones. When I was a youngster in school, we invariably had one or two people in the class who were walking around with a withered leg or something from polio. It's those kinds of things that just don't happen any more. That's where pediatrics was born:

basically in the prevention of those illnesses, rather than treating after the fact.

But apparently vaccinations of pre-school children is still a problem?

That's an absolute fact, and it's absolutely astounding. It's always been a difficulty for pediatricians to understand when they have an encounter of any kind with a parent who really doesn't care about their own child. That's hard — it's a hard intellectual hurdle. And when you encounter face-to-face, it's most difficult; it's very frustrating.

They really don't care or don't understand?

No, they don't care. They have other interests which does not include their children's health.

But by law you have to have a child vaccinated to get them into school.

Oh, there's only so much you can do with laws. Certainly there are more children vaccinated because of the school requirement. But from a medical standpoint the better time to get the job done is between birth and eighteen months; that's when we do most of our immunizations. There isn't, nor could there be, a law that could take care of that problem. I have no idea of how that problem could be solved other than making it easy for people to get immunizations. We've already done that, and we still have a poor numbers. But you don't have a gun to their head, and that doesn't mean they're going to show up and have their child immunized.

You were appointed to the Board of Medical Examiners. Who appointed you, and how did that come about?

Governor Robert List appointed me to the Board in 1979. I have no certain knowledge of why Governor List appointed me. I knew him socially, but not well, and I was not a contributor or anything like that to his campaign. I would suppose that I was named because I had been in positions of leadership, and positions where good judgement was required, and that's about what you're looking for with somebody on the Board of Medical Examiners. Someone who is competent in their field, but who also had experience and a record, a track record in having other doctors show confidence in that individual. I'm trying to get away from the word popularity because that was never a strong suit for me; not so much popularity but somebody in whom the physicians trust.

You did mention when I first talked to you that you perceived some problems with the process of choosing people for the Board of Medical Examiners, that a political appointment by the government wasn't necessarily the best way to bring someone to that post.

It is a very difficult thing. I don't know how other states do their appointments, but I think the kind of unstructured appointment that is presently in use is potentially dangerous. You could conceivably have people on the Board with their own agenda, not have the agenda the Board has basically as their working agenda. Fortunately, the Board is big enough so that if somebody were to be a member of the Board and be disruptive or divisive in any way, it wouldn't have a whole lot of effect on the work of the Board except that it would make the work more difficult.

I certainly think that the non-physician members of the Board should be appointed by the governor in whatever way that he should decide. But I think the physician members

of the Board should be selected from a panel of qualified physicians nominated from the general population of physicians. That is to say all the licensed physicians in the state as opposed to the medical society, which may or may not be all licensed physicians. The licensed physicians are basically the population that the Board serves and whom the Board is responsible for governing. So that selection process should include democratically all the members of the licensed physicians in the state, who would then, through some type of nominating process, present the governor with perhaps five or six names from which to choose. In that case you have the assurance that the doctor not only had the approval of the governor, but also had the trust of the practicing physicians.

What would keep that from being a popularity contest? You mentioned you didn't particularly like that term.

Well, anybody with any sense would be more interested in having a fair and trustworthy person on the Board than having their friend or the most popular doctor on the Board. What the Board does is very serious, and when they have a disciplinary action and the doctor's license is on the table, he would like to have the fairest person that he could possibly find on that Board. That's the direction I'm talking about. If, for instance, he had to go before the Board, and the Board was composed of people who were friends of the governor's wife and the friends of local politicians — whatever type of selection process takes place — that would be frightening to the physician. And it may or may not be fair to the physician. But if the physicians who were to be governed by this person and who were to be disciplined by this person, by these people, had input in

their selection, I think that would make that relationship much healthier. If somebody is going to take your license away, and he was somebody that you voted for because he is a fair guy, you kind of figure, "Well, a fair guy took my license away, and I still don't like it, but" You know, it is not quite that crude, but that's the point I'm trying to make.

During the period that you were on the Board, there were a number of important issues that were raised. I am interested in your opinion, a little insight into what was going on with the Board at the time that discussion occurred and action was taken. In 1979 there was discussion about requiring Continuing Medical Education (CME).

Well, as a matter of fact, at my first meeting on the Board I turned out to be the swing vote on that particular issue. I voted against a mandatory CME. I have to qualify that by saying that if every doctor in Nevada was in Las Vegas or Reno, I would have voted very strongly for the CME. The point there is that a practicing physician in Las Vegas, for instance, can get his CME by having a free breakfast at UMC or Sunrise Hospital. All he has to do is get up an hour early, go over to the hospital, get a free breakfast, and listen to a lecture. He gets an hour of CME. The doctor in Wells, Nevada, if there is a doctor in Wells, Nevada, has to hire somebody to come in and take his place, while he goes to a distant city and spends three hundred dollars a night for a room. He is not making any income at that time, so he's taking a forced vacation to go to school to accumulate CME.

CME is a major industry, and it doesn't necessarily advance the physician's knowledge. If somebody doesn't want to be advanced, you can't make a better doctor unless they want to be a better doctor. Having the CME is just a

small piece of the pie, and there is no guarantee that you can have a better medical community because you have CME requirements. I don't think that's ever been proven that requiring them to go to class makes them better. Many doctors use that time for a period of rest or what have you. [laughter] It doesn't necessarily bring about the end that it's designed to do. So understanding that, and understanding the problems of the rural physician in the state, I voted against the CME requirement.

I have an addendum for that. In the latter part of the 1980s a very good personal friend of mine, Senator Bill Raggio, informed the Board that he felt we should require CME. It would be better for the Board to enact that legislation than for the state legislature to do so. Understanding his language, which was very clear, we enacted a CME requirement. However, I think we made it realistic in numbers because some states are a little unrealistic.

As I say, it's inherently unfair to have the same requirements for rural physicians as you would for an urban physician who gets his CME cheap and easy and doesn't have disruption of his practice. Nor does he leave his town without a doctor for a given period of time. Those are the issues that we have in this state, where there are a lot of doctors out there in the rural areas who don't have access to the stuff. There also is the argument that you could get it by mail. But anybody who has ever done it knows that it takes a great deal of get up and go. If you're seeing thirty or forty patients a day, it's hard to go home and do your CME work. It's kind of impractical to expect that.

But we kept the CME down to a reasonable level, so we were sure the program was in place and that there were safeguards in it to make sure that it was being complied with. That's not a good sentence! We kept the

numbers down to a manageable numbers for the guys out there that are really doing the hard stuff in the rural areas. So that's the whole progression of events, and if it sounds like I'm on both sides of the fence, that's exactly right, because I was, for the reasons that I mentioned. [laughter]

One of the other problems that occurred while you were on the Board was the difficulty with the so-called offshore schools.

That was an issue which was a national problem. The offshore schools presented a problem to everybody because there was no way of determining whether these people had the kind of basic background that we require from schools that are in the United States. Schools here are well-known and share standards and tests and so forth. The various medical schools have certain requirements in terms of hours and in terms of emphasis and in terms of outcomes. All of these things were measured, so we knew basically what kind of product we were dealing with.

We were never quite sure about the Caribbean schools. I think associations and boards in the U.S. had begun to take some initiatives, and the states started rolling over one at a time. As soon as California decided to close the state to Caribbean or offshore graduates, then we just followed suit. We were in the throes of what had happened elsewhere; we were in the throes of determining the legality of doing it ourselves. Then I guess when four or five other states did it, we just jumped on it and did the same thing. It made it very simple, and it wasn't an agonizing decision anyway.

Did it exacerbate the situation for foreign medical school graduates? One of the problems that seems to be consistent for that situation

is frequent delay of transcripts and materials from different schools.

Sure, credentialing is often quite a problem. But since we have a three-year postgraduate requirement, most of the credentialing and the screening has been done by a residency program in another state. We were relieved from that responsibility, by and large. If somebody went to school in India and had the credentials to be a resident at Charity Hospital in New Orleans and spent three years there, we felt fairly comfortable with the fact that the credentials were, in fact, in order. So, therefore, all we asked for was the copy or the verification of a license from an approved medical school no matter where it was. That made it easy, kind of automatic, and there wasn't a big intellectual exercise there at all.

One of the trends with the Board is an increasing involvement in the legislation that affects medicine and the supervision of physicians. While you were on the Board, they made the decision to share a lobbyist in order to better track legislation. How do you feel about the necessity of the Board being involved politically in that way?

The whole function of the Board derives its authority and its missions from the state legislature. So depending upon the needs of the state from time to time, those laws need to be changed. Witness the change we made at the state level that required three years postgraduate education in 1985. It was recommended by the Board to the legislature, and the legislature enacted this as part of the Medical Practice Act.

In all of that is an example of the appropriate relations between the Board of Medical Examiners and the state legislature, which represents the people of the state of

Nevada. If the Board didn't have a relationship with the legislators or the legislative body, I think it would be very difficult to know what the mission is, number one, and number two, to carry it out. So it's not only a question whether it's a good thing to do, it's an absolute requirement that the Board be in concert with the state legislature.

You will have difficulties and technicalities and different approaches and different ways to solve a problem, and there will be conflict in that regard. But that's part of every legislative process, just like the Senate and the House have different ways of coming to a solution to do things. Well, it's the same way with the Board. Just because we didn't agree with the way they did everything doesn't mean that we weren't going in the same direction. If we are not going in the same direction, that would be the day I would get off the Board, because it wouldn't make any sense.

Part of the increasing complexity of the Board's function is related to impaired physicians. Do you think awareness of physicians' problems, either substance abuse or malpractice or whatever issues these physicians are dealing with, has been positive?

Well, the initiative was started by the State Medical Society in regard to impaired physicians, which took a couple of years to coordinate with the Medical Board. Once that happened I think that it became, on two levels, a great deterrent. It provided early diagnosis and treatment of the impaired physician without, hopefully, destroying a career. You could get these people before they were too far gone, get them straightened out, get them treated, and get them back in practice. That has happened in a number of cases I personally know of. That was just beginning when I left the Board, so I can't really speak

extensively to that. But that was an absolutely wonderful and timely initiative that the Board did in conjunction with the State Medical Society.

As far as discipline is concerned, with the discipline of people who are guilty of gross malpractice or gross social behavior, I don't think there is very much chance of remediating or improving these people's position and putting them back into practice. Maybe there are some exceptions, but by and large those people are so far off the wall that your main thrust is to protect the people of the state of Nevada from this individual. You do whatever you have to do to keep them from doing what they're doing.

That basically is my feeling about those functions. They are two separate things with two very separate outcomes. If you get the impaired physician early enough, you can salvage him. The psychopathic or sociopathic physician is almost untreatable by definition, and it's just a question of protecting the people of the state of Nevada from these individuals.

Would you explain exactly how the Impaired Physician Committee works?

The Impaired Physician Committee is staffed by a group of physicians, either those who are interested or ex-impaired physicians themselves. When someone who is possibly impaired is found bouncing off the walls in emergency rooms, or is drunk and disorderly, that is reported to the Board. The Board in most cases would have a two-track process. They would have a disciplinary process in effect on that physician, and they would also refer him to the Impaired Physician Committee. If the physician went to the Impaired Physician Committee and entered a program, that would certainly shave the whole process on the disciplinary side.

If the physician failed to go to the Impaired Physician Committee or failed to follow through with the Impaired Physician Committee's recommendations, then the hearing about his being drunk in the emergency room would have a whole different tone. There would be a lot less forgiveness in the hearts of people who were sitting on the Board for that particular instance. Using the wall-bouncing incident mentioned earlier, if Doctor A went and took the cure, and came back and was behaving himself, you might have a small punishment. But Doctor B, who was arrogant, who said it never happened, "I'm not drunk and I don't need help," then he would be in danger of losing his license very soon. So I think the coordination is about as good as it can get, or at least it was the last time I had personal contact with the Board, which was in late 1988.

There's often reference to an agreement that's worked out between the physicians and the Board.

It's a contract. The physician is under contract. You go before the Board and say, "I have done this thing, and I am seeking help. I am going to receive out-patient therapy for a specific number of months under the care of Doctor So-and-so under such-and-such a clinic."

Then that's fine. We notify the clinic: "If Doctor X doesn't show up for his appointments or he drops out of your program, notify us immediately." Then we go back, and say we originally gave you a punishment, but suspended the punishment as long as you stayed in the program. Now, if you are not in the program, you're out. You know that could include loss of license. For instance, with the doctor drunk in the emergency room. You say, "OK. We are taking your license away from

you. You have no license." We suspend that action, which means we hold it in abeyance as long as you are in the program. The first time we get a letter from the Impaired Physician Committee that you failed to attend the meetings, your license disappears. That's pretty clear, pretty basic stuff, and I like that. You're given a chance, but you either comply or you're out.

Do most physicians comply?

Oh, virtually all of them. I think, it's like 99 percent if you get them early enough. But when you get somebody who's really not only impaired by drunkenness or drugs or something, who is just flat-out crazy, there is nothing you can do for them.

What is the process by which an incident would be brought to the Board's attention? How far does it have to go? Can you work on rumor?

Well, the license to practice medicine is not a right; it's a privilege. So when your performance is at question for any reason, the State Board has the authority and the obligation to investigate that. Somebody may not like you and say, "I saw Doctor So-and-so, who was tipsy at our party at Caesar's Palace on New Year's Eve."

The Board's going to say, "Really?"

If you say, "He was on call for brain surgery at Sunrise Hospital on New Year's Eve, and he was tipsy at Caesar's Palace," now we have a problem.

It doesn't mean that what a doctor does on his own time doesn't count. What it means is that the behavior has to be very grievous, outside his scope of practice, to justify the bother of doing a disciplinary action. Certainly, if the administrator of the hospital says, "This guy was in my emergency

room three times in the last month, and he was just ripped. He couldn't see straight, he couldn't write his own name, and he was walking around," then those decisions are very easy; you don't lose a second's sleep over that because it's so straightforward. [laughter] You have to do what the law enables you to do to get this thing taken care of in the most direct manner possible. That's the way it works, and it works well.

Do you think physicians present special problems in issues like this because of authority?

Well, physicians, number one, are basically people with a strong ego. So when you tell somebody with a strong ego that you don't like what they're doing, then you're liable to get any number of excuses, arguments, or explanations. So when the Board brings somebody in for a deed that they find grievous, they have the evidence. And they have good evidence. They don't bring people in frivolously, just because they get letters saying, "My doctor was rude to me." We discourage rudeness, but we really can't control that. Or, "My doctor charged me too much money for my operation." We have almost no control over that. But for the type of things over which we do have control, it's a very definite line. You have a stack of charges, and you go through them very, very quickly to see which ones need further investigation. It is not a Herculean task.

One of the members of the Board, say, the secretary, may go through the initial evaluation and decide that three out of fifty need to be brought to the attention of the Board. He's making a decision because those three are gray, definitely gray. The ones that are white he doesn't bother the Board with. We trust his judgement; he's been doing it for a long time. That's the function of the Board secretary.

Once you get into the gray areas, any number of people will come to the doctor's defense and rightly so. They'll say, "Have you done this, or have you asked that, or have you checked this? Have you done that to see that there's fair play, and that there is a due process taking place?" Because, even though it's a privilege and not a right to have a license, there are a whole lot of ramifications in not having the privilege once you've earned it. We feel very sensitive about that because we all have the same privilege. We all like to keep it. So you do unto others, as it were.

There are an increasing number of cases where physicians appeal the decisions of the Board, even to the State Supreme Court.

If you do something a physician doesn't like, he's going to take every avenue he can to rectify what he thinks is wrong. And the Board feels the same way. They're going to take it as far as they can to rectify the wrong which they perceive as a person's continuing to do what he is doing. People will protest the decision of the Board because the Board's decision is sometimes harsh. Nonetheless, if the Board didn't make those decisions, I think the result would be whole lot worse than suffering through an appeal process.

The practice of medicine is changing rapidly. A part of that change is the actual structure of physicians' practices. You are in a type of group practice. Could you explain what managed care is?

OK. Managed care — I'm not real fond of the term, but I don't know if I have an alternate term. Managed care is a system which has been developed to take care of the current problem with medicine, which is basically cost.

Is medicine good today? Absolutely, it is excellent, wonderful. Is it cost effective? Absolutely not. OK. So there has to be a method whereby we can produce the quality without incurring excessive and obscene cost. Now, part of the problem is not only the cost of technology and drugs and stuff like that, but also the fact that there are just too many doctors doing too many things: too many tests and too much of everything. This is a reflection of society's desire to have everything fixed; there is no symptom out there that isn't going to get a pill.

The problem is pills have a price tag. Not only the one that you pay at the pharmacy, but also with what it does to your body. Surgery has a price tag. Not only the one the surgeon charges you, but what it does to you. Most of it is done for you, but some of it has results that are unpleasant. So the whole issue is what we want to do — “we” I say as in medicine in general. What we want to do, what we need to do, but we should not be doing the stuff that we shouldn't be doing.

If it turns out that we're doing twice as many hysterectomies than are really necessary, then let's come together and decide what are the real indications for hysterectomy, and what are the flighty or transparent or frivolous indications for hysterectomy. If we do that, then we are on common ground. We've done two wonderful things: we've devised a system to treat people appropriately, and we've done something about the cost of medicine. This then will enable us to do more and better things for the people who need it, rather than just give everybody everything that they want.

Now, the whole concept of managed care is that you have on the one side patients who want care and need care. You have care on the other side. Managed care puts the primary care physician between those two things,

and says this person is more of an informed consumer by definition than the untrained person on the other side. When the patient on the untrained side goes to seek help from this absolute maze of specialists and services and tests and so forth, they go on their own, looking for what they think they need. They are really working without direction and 90 percent of the time are either going to be going to the wrong person, or spending unnecessary dollars by using specialists for something where a very simple procedure or diagnosis could be made by primary care physicians.

I despise the word “gatekeeper” because I think from my Catholic background, that stands for a person who stands in judgement, and says this person is worthy or this person is not worthy. That means the worthy people get all the goodies, and the unworthy people do not. So a “gatekeeper” concept is, to me, a very poor one; the term is poor.

I always prefer to think of the primary care physician as an informed consumer of health care, as the patients' advocate as it were, because he knows what the system can do. He knows when the system should be brought into play, where and when, who should do it, and under what circumstances. Just for instance, we see a common skin disorder in childhood: impetigo. I see this in the office frequently, and it is usually in conjunction with something else. It is very rarely a primary problem, but can be a primary problem that is brought to the office. We treat the impetigo at a minimal cost with the minimal prescription. There are people, however, who have leapfrogged the primary care physician or pediatrician, and taken a child's record to a dermatologist.

Now, they are spending three times as much for the office visit, and they're being actually treated by a person who, although they're experts in skin diseases, see less

impetigo than the pediatrician. It is costing three times the money to see the person who doesn't know as much as the primary persons. So they are wasting a lot of money and time, and not getting a very good product. If you had initially seen a primary care physician, he might have said, "Well, I don't know what it is, but I'll send him to a pediatrician. He'll know what it is, and we'll get the thing solved very cheaply and quickly." If it's a rare disease that the pediatrician or the family practitioner doesn't understand, they will refer it to a dermatologist, and we are using the dermatologist's services appropriately.

For the same given illness, we now have two different price tags, with one three times the cost of the other. Preventing that makes a lot of sense. It doesn't mean that the patient has done something bad; it means that the patient is uninformed about the issue, about the cost. It may sound like a little thing if we are talking about the difference between fifty dollars and a hundred and fifty dollars, but if you multiply that by a couple of million times a day, you get into some serious money.

The other thing is that it's OK for a person who's not paying their bill, but whose insurance is paying the bill, to say, "Well, I have insurance. I'm going to go to a dermatologist. I don't care to waste my time seeing a pediatrician. I want to go to a dermatologist because they're smarter and they're more expensive, so they must be better." Which happens to be wrong, but that's the thinking, so they proceed to the dermatologist. Now your insurance rate goes up because of this kind of extravagant behavior. Is that fair to you? I don't think so. In other words, the patient has an obligation to behave in a responsible manner and not use the medical care delivery system in an obscene manner. That doesn't take a whole lot of discipline; however, it does require some structure.

That's what managed care is all about. We're not interested in pushing doctors around or making medicine a cookbook procedure. What we are interested in is not doing the unnecessary procedures and treatments, and not running up the incredible bill that everybody might have to pay. So it's a pretty rough analogy, but in the United States health care has grown to a point it would be like if General Motors or the automobile industry developed such that every gas station in the country was building their own car. OK. You'd have some wonderful cars out there; you'd have some very bad cars out there; you'd have some very expensive cars out there. The law of large numbers is that people who make a lot of automobiles can make them more efficiently, and they can make them better and faster and cheaper. Our health care delivery system is basically that: we are creating five hundred thousand different automobiles, or a dozen different practices in these various offices throughout the country.

There is very little control over the ambulatory care. The practice in medicine is called, "make it none." There is virtually no control over the ambulatory care practices in medicine except insofar as the patient is displeased. When your behavior is so far out of line, you can be called to the attention of the Board of Medical Examiners. And there are big, big areas between just making mistakes and getting to that point.

We need to come together, come to consensus: these are the tests that are required to work up a headache under these circumstances. You needn't get an MRI on every child who has a sinus headache. That's an obscene use of the system. Well, if the doctors have a guideline that is written by the smartest people in the land, they would say, "OK, this is the way you should handle a headache in most cases." If there are

exceptions, then you have consultants who you could refer these types of cases to.

It's very much like the immunization program. No pediatrician in the county has time to evaluate all the vaccines studies to a point where they can say, "These are the vaccines that I'm going to use in my office." What we do is we relegate that responsibility to the American Academy of Pediatrics. The American Academy of Pediatrics takes the thirty smartest pediatricians in the country every year and puts them in one room, and says, "Hammer it out. Give us your result." And they tell us what the immunization program will be; what changes are made. We know them and trust them, and it's worked out very well.

So is that cookbook? Yes. Is that OK with me? You bet. I don't have the time to do those studies, to convince myself that the new vaccine that was developed in Helsinki, and then tried out in Japan, and then came to the United States and was finally approved by the FDA, is what I need. I have somebody that does that for me. They are doing a cookbook for me, and I love it. That's great. That removes a lot of work load from me.

The methodology of payment is where the private doctor gets into a problem because he's dealing with a number of managed care systems, and they all have their own rules and paperwork and so forth. That'll make you crazy by Christmas. But the system that we work in here is we have only one managed care system, and this is manageable. But other managed care systems are unmanageable by definition. What that will come down to is that there will be physicians who will group themselves, either with clinics without walls or in some type of formal grouping, so that they can deal with managed care entities and do these things in an orderly manner. That's what managed care is all about.

The concepts are not entirely foreign to most people if they really take the trouble to understand what's going on. Everybody resists change. That's a given, especially with people who are doing financially well. To ask them to change is an unpleasant experience for them. Sometimes the marketplace asks them to change. For instance, if a person charges a lot, very high fees, but the country's in a depression and nobody has any money, market pressure forces him to change the way he does business. It has forced him to lower his fees.

The managed care business doesn't necessarily try to squeeze the doctors per se, but they do, through various payment methodologies such as capitation, pay the doctor differently than he's used to being paid. With capitation you get paid before you do the work. So if I do a hundred dollars worth of work on the twenty-eighth of the month, and I'm on a fee for service basis, I might see the money five or six months down the line. OK. If I do a hundred dollars worth of work for a managed care organization that has capitated me by the number of patients that I have, I would have been paid on the first of the month. That hundred dollars is already working for me.

Now, we discount; we ask for a discount. So instead of getting a hundred, I get eighty-five. My question is, "Would you rather have the eighty-five for sure thirty days before this event or a hundred dollars maybe five months down the line?" Almost anybody in their right mind would go for the eighty-five dollars up front. So that's how the discount works. That's fair. Most people understand it, have no problem with it whatsoever.

It doesn't mean a doctor's working for less. These are doctors more divorced from the cost of doing business. It's all kind of smoothed out. There are certain areas where entire sets

of specialists are overcharging outrageously. Well, we don't pay them outrageous fees. We just don't do that. Fortunately, we've been able to survive and to still have quality people who work for us, because we are able to pick and choose the physicians we want. In the long term, a lot of physicians see the changes that are coming, and they are willing to take a little less in the short term to be assured of a relationship in the long term.

The guys who are flagrantly overcharging right now may get away with it for a little bit longer, but they're not getting away with it forever. I see some of the specialists in two distinct camps now. Some of them are just grabbing as much as they can, as quick as they can, because they know the golden goose is going to be gone real soon. Others say, "I think I'll become pals with the goose and will share in the financial benefits of doing what we are doing, and still have the quality relationship with medical care."

Everybody will do well by reducing inefficiencies. The National Clinic for Quality Assurance is an independent group of physicians and lay people who evaluate quality of care in managed care organizations. I'm an examiner for this national committee.

Managed care is all about improving the product, improving the patient's lot and the patient's access to medical care, improving the patient's cost of medical care. The government can posture all it wants, but the people end up paying for it. I don't care whether it's Medicare, or insurance, or whatever. Where does that money come from? It comes from us. Everybody is paying for this obscene medical care, whether it's being given at UCLA to somebody who's an illegal immigrant, or whether it's being given in Sloan-Kettering to one of the Astors. It still costs us all to maintain this payment system, either by taxes or insurance premiums; it still comes out of

your pocket. So anything we can do to make that efficient I think is positive. It is positive medically on the quality improvement side, on the fact that we supervise our physicians, we choose our physicians, and we are proven to do an appropriate level of care at less cost by using this method. We have generally provided easier access to medical care.

Is there a downside to this?

Well, the downside is that it's structured. Not everybody likes structure. I mean there are people who wear cowboy boots in New York City, you know. Never seen a ranch or a horse — they just have to be different. There are people who do not like the fact that they have to go to a particular office or a set of doctors. You obviously don't have the freedom to go to a specialist on your own. You can't just go in and say, "I want an x-ray," or, "I want an MRI. I have a headache." You can't do that. And that's ultimately to the patient's benefit. But not everybody sees that as a plus; they see that as a restriction on their freedom. I have a hard time with that, but I can tell you that's the feedback I get. Some people feel that this is an imposition on their rights, or a restriction on some of their rights to choose a doctor.

G. NORMAN CHRISTENSEN, M.D.

Dr. G. Norman Christensen is a native of Rochester, Minnesota, born in 1935. His family moved to Arizona in 1945, and he graduated from high school in Globe, Arizona, in 1953. Dr. Christensen received a B.A. in Chemistry from the University of Arizona in 1957 and his M.D. from the University of Tennessee Medical School in 1961. He did rotating internships in Phoenix, Arizona, and Minneapolis, Minnesota.

Dr. Christensen was commissioned a captain in the U.S. Air Force in 1961, completed his surgical residencies in Albuquerque, New Mexico, then was stationed at Sheppard Air Force Base in Wichita Falls, Texas. He moved to Ely, Nevada, in 1968 and joined the Eastern Nevada Medical Group, where he has practiced since. Dr. Christensen was certified by the American Board of Surgery in 1967 and recertified in 1982.

Active in community and church, Dr. Christensen has also been involved in medical politics. He is a member of the Nevada State Medical Association, serving as president, 1991-1992, and served on the Board of Medical

Examiners from 1977 to 1981. On the national level, he has served as an alternate delegate and a delegate to the American Medical Association.

G. Norman Christensen, M.D.: I was born in St. Mary's Hospital in Rochester, Minnesota, in 1935 on May the sixteenth. My father was with Chevrolet, parts and sales, and my mother was a nurse who worked at St. Mary's. She received her education there and graduated in 1933. We lived in a small town called Zumbrota, and my mother was one of the early commuters. She drove twenty-two miles back and forth to work every day in 1935.

We left Zumbrota in 1941, and I started my education in Rushford, Minnesota. We moved to Wickenburg, Arizona in 1945, and I went there through first year high school. Then we moved to Globe, Arizona, and I graduated from Globe High School in 1953.

Anita Watson: What prompted the moves?

My dad's work. As I say he was with Chevrolet in Minnesota, and in Arizona he went with Standard Oil. Globe was kind of an interval step from there after I graduated from high school. After I finished high school, they moved to Clarkdale, Arizona, where he was full service distributor for Standard Oil for about twenty years.

I went to the University of Arizona and graduated in 1957 with a Liberal Arts Degree in Chemistry. I had applied to the University of Tennessee and was accepted for the December 1957 class. Tennessee was a school that had retained the World War II pattern of quarterly classes, so you could start in December, March, June or September. That's where I went to medical school and graduated in 1961 with the March class.

Why did you want to be a physician?

Well, as I say, my mother is a nurse, in fact an O.R. nurse, and she worked with Will and Charlie Mayo during her years after she graduated. She ran an Operating Unit Number Four, and so I had kind of been with hospitals in Wickenburg, the first place we moved and it was right after World War II. The fellow who was the only physician there had just survived a plane crash and lost one eye and part of the use of one of his arms. I would say he was my role model. He had been trained at Tennessee, an internship at Vanderbilt, and then went to the West. He delivered babies, he took care of anybody who was sick. He was a Fellow of the American College of Surgeons; in those days you could do that. In fact, I have classmates who went through on a program which allowed two years of formal training, and then you precepted with somebody who would sign and say that you were ready, and you could take your boards and be boarded and a Fellow

of the American College of Surgeons. So he had been in the days when you just sent in a hundred cases that you did, and all of your friends said you were very clean, reverent, and those other twelve things, and you were a Fellow of the American College of Surgeons.

When he operated on my colt when I was about fourteen years old, I thought, you know, that's kind of what I want to do. I recognized that unlike the way he had come through I would have to have formal training. That's part of what motivated me to talk my wife in letting me spend four extra years in penury until we got out. Les Moren and I like to compare who made the most money. I made thirty-five bucks a month when I was an intern in 1961. [laughter] Thank goodness my wife had a good job.

I ran into Floyd Braillier when I was a first-year resident, and I was in a meeting of the College of Surgeons in Phoenix and noticed this old gentleman in the same meeting that all of us noisy young fellows were in. That kind of impressed me. He had done a hysterectomy on my mother in 1957, I think, and when she needed some further surgery in 1986, they wrote for the records back in this little hospital in Wickenburg. Mother got a call from a lady that she had worked with when she had been there in Wickenburg. She had been working as Dr. Braillier's office nurse, and he was still practicing. He just died April of 1991, I think it was.

After I got my M.D., I spent three months in Phoenix at Maricopa County Hospital, working as an intern. I had matched through the matching program with Minneapolis General, so that's where I did my complete year, finishing in June of 1962. I was able to be accepted by the Berry Plan, so that I went right into my residency.

Would you explain the Berry Plan?

It was a program that Senator Berry came up with to get specialists in the military. The history is, of course, we drafted doctors, even though we didn't draft anybody else. Being of prime age, I knew I was going to serve somewhere, so this gave me an opportunity to finish my surgery training and then go into the air force as a fully trained general surgeon. In fact, I passed my board and became certified while I was in the air force.

I did my residency at the University of New Mexico affiliated hospitals. Actually this was an evolving program. At that time I was selected by the dean's committee at the University of Colorado to go to Albuquerque, and over the time I was there, the University of New Mexico School of Medicine evolved and had the first class the year I was the second-year or third-year resident.

As I was saying, when I finished there, I went in the air force for two years, stationed at Sheppard Air Force Base, Wichita Falls, Texas. As a consultant surgeon general, I visited the hospitals in that particular area. The air force divides the medical practice up into six areas and so we covered Oklahoma, Texas, and New Mexico for all their smaller hospitals.

I had met my wife while I was in Memphis, and we were married when she graduated from the University of Tennessee in June of 1961. We spent those two years looking for a place to practice, pretty much in the Southwest. My wife kind of recognized that after my three and a half years, three years and three months, in Memphis that I wasn't going to live in the South or Midwest. I knew Arizona very well and I knew a little bit of New Mexico and Nevada, and learned a lot about New Mexico while I was there. Through the AMA Placement Service we found Ely, we made a match, and I came here on July 8, 1968. As I said, I had passed my boards in general surgery in 1967, and after I came to

Ely I was inducted into the American College of Surgeons in 1970, and I recertified in 1982. I took the practical boards in 1977 and passed that, and so I took it in 1982 and was recertified in 1982.

You went into practice through an AMA matching service. How did this work?

Well the AMA has had a placement service all along. In those days, of course, everything was done by hand. It wasn't a computer like it is now, where they punch a few buttons and print you up opportunities in your specialties in whatever part of the country you want to go. There were these little wish books that you could leaf through, you know. We'd sit on the couch, and we would leaf through them looking for where we wanted to go. We had once visited several places in Texas, and we kind of wanted to go back to New Mexico, but knew really only Albuquerque. A general surgeon got off the bus every time Greyhound came in, so there really wasn't any need for general surgeons in Albuquerque. We were just kind of looking, and Ely worked out.

This was 1968. What was Ely like in 1968?

I grew up in eastern Arizona, and my most formative years were in eastern Arizona and Globe. I kind of knew about Ely, because we had copper mines and smelters there, and there were copper mines and smelters in Ely. They didn't have unified negotiations in the unions in those days so that when they had a strike in Globe Miami the guys would come up to Ely and McGill and work until the strike was over, and then they'd go back. And when the guys in Ely and McGill had a strike, they'd come down to Globe and work until the strike was over. So I kind of knew where Ely was.

Ely was kind of a company town. McGill, of course, was a totally company town. It had only been 1961, I think, when Kennecott started selling the houses to the people. They had separated themselves from health business, and they tried to kind of get out of the housing business.

It was small. They were building the hospital in October when I interviewed here. The hospital was finished in the early part of 1969. We opened it up in June, I guess, and we were pretty much the edge of town. All this you see out here was not here then. I bought eighty acres out here, and there wasn't anybody but me for a number of years. The town has grown since then; Kennecott closed the mine in 1978; shut down the smelter in 1980.

Practice-wise there were only three of us, and we were so busy we, you know, really didn't notice, or probably cared, if any more people showed up or not. Following that, of course, through the lean years, there really wasn't a single solid paternal presence then. The community went through quite a turmoil. I don't think it was until last year, when they blew down the big stack in McGill, that folks realized that Kennecott wasn't coming back.

Through this time various operators had come in. Silver King, for a while, took over the operations in Ruth and provided seventy or eighty jobs. But it was nothing like the thousand, eleven hundred jobs that Kennecott had. As the gold rush kind of subsided, the gold that was supposed to go to five hundred an ounce didn't go that high, and so things kind of petered out. Then Magma came in, and if we can get the government to lay off their backs, probably things will go back a little bit to being like they were in 1968. Magma will be going after the copper, and gold and silver will be a by-product.

Will they go after what's left over from the earlier mining and try to get the microscopic stuff?

Technology has changed. They would use electrowinning process, which is much more efficient than the smelting, which was the technique which was used in McGill.

So we practiced medicine; as I say, for quite a while there were just the three of us, Dr. Jones and Dr. Wicker and myself.

Did you have this clinic set up then?

Yes. This clinic was chartered in 1961. Kennecott got out of the medicine delivery business in 1961. Prior to that time they owned the hospital; they hired the doctors; they hired the nurses; they provided the maintenance. They provided an ambulance, and then there was the presence downtown of a couple of practicing physicians. In 1961 that all changed as the physicians who were here kind of created a loosely affiliated group, and then in 1964 it was incorporated. This was this the first incorporated group practice in Nevada. When I came here around 1967 to interview, they were very seriously considering building this building. We did build it in 1969, and so it opened about three months after the hospital opened in October 1969 and has been here since.

What did the other two people specialize in?

They were in general practice and Dr. Wicker, of course, is on the teaching staff of the Family Practice Program in Las Vegas.

Did they provide OB/GYN?

They did, yes. Dr. Jones is still here. He practices in the hospital clinic now. He had

mandatory retirement at age sixty-five in 1973 from our corporations. He went to work for them. He does a little surgery, a little OB; mostly sees his old friends of which there are a lot of after thirty-three years. And the other doctors — Dr. Wilkin came in 1972. His daughter was the first offspring of a graduate to finish at the School of Medicine at UNR. Some came and went over the years. Dr. McHugh came out of the Boise Family Practice Program and he's a Nevada graduate. He's been here three years now. Dr. Nicholson came out of the Family Practice Program at Nevada, Reno, this year in July.

What about in the town itself with the population? Do you have people moving in?

Well, yes. When the prison was built in 1989, this changed the complexion somewhat in the health community and certainly provided another, oh, probably three million dollars a year payroll. That's kind of what's held the community together. We finally got the Great Basin National Park, and the community became oriented more to a service industry, building more on the housing and motels, restaurants and that sort of thing. This is a major philosophic change to go from mining to service which is something else.

People are not attuned to doing things for themselves. In the old days if you really needed something, you talked to somebody at Kennecott, and more than likely it got done; the ball park got built or whatever project needed to be done. We found out you got to raise taxes, which is tough because 97 percent of the county is either in the state or federal ownership. So you have only 3 percent of the county in private ownership providing property taxes to provide the schools, and the police, the roads. This county, it's bigger than six of the states; bigger than New Jersey,

bigger than Delaware, bigger than Rhode Island, bigger than Vermont, bigger than New Hampshire and Vermont put together. And we've got only ten thousand people.

What's the population in Ely about now?

Oh, probably seventy-five hundred. Outside you've only got nine hundred and one; probably fifteen hundred in McGill. As I say, we go seventy miles to the west and sixty miles to the east. Baker, of course, is growing, with the Great Basin National Park.

So the community has had to shift its focus. You mentioned patronage before in reference to Kennecott, and that is something that they've lost.

Kennecott was the father. In the halcyon days of Kennecott, the general manager was pretty close to God. You had a strong, ethnic-type community. McGill was as segregated as you can find anywhere and had Austrian town, Greek town, Jap town — all these families were cordoned off into these various groups. Each had their spokesman, and most of them didn't speak English. Out of that grew many of the local merchants. These were the fellows who learned English. Kennecott tried to keep it that way; keep it segregated. The general manager drove around and saw that everybody's yard was trimmed, and Kennecott maintained the houses for them, so when the house needed painting, it was painted.

The charge has been made that it was painted faster on — what was it called? On the hill? The group where management lived?

Well that was segregated, too. Tommy Collis used to talk about that; he was from a

Greek family which grew with McGill. There were the Irelands: Bill was athletic director at UNLV and this sort of thing. But Tommy used to say as things went on with Kennecott, you'd have to move up the hill. His house was no longer down in Greek town; he was up on the hill. It was a very segregated community, and they wanted to keep it that way. The problem is they sent all their kids to school together.

Was Ely like that at all?

No. Ely was kind of, you know, the center of government; they moved the county seat down from Hamilton after Hamilton dried up. The courthouse and county government were here, and the main business community grew up here, so that was sort of the center of the private part of the community.

Old Ruth and Kimberly closed up, and they moved a lot of those houses down into what's East Ely. There were various real estate developments and ventures to line the pockets of those that were smart enough to divide up the property, the folks who would buy the lots and all that. But a lot of these houses you see in East Ely are houses that moved down from Ruth.

What kind of practice do you have? If you had to describe your practice, what is the focal point of it; the thing that's most obvious?

Well, as I say, I'm a general surgeon, and when I came here in 1968 that's what I planned to do. At that time there were five family practitioners here so that the emergency room and OB and all those things were covered. So general surgery was pretty much what I did other than take my turn in the emergency room on weekends. Then as the doctors died, Dr. Anderson, a Board member, died, Dr. Ririe died and others left,

and more and more of the general parts of medicine fell to me because there was no one else to do it.

The liability carrier a few years back decided that only certified physicians can do C-sections. So after, you know, Dr. Jones had done a few thousand and Dr. Wicker had done probably over five hundred, they couldn't do them anymore, and I did the only sections for a while. We finally explained to the liability carrier that's how things were; then I didn't do quite so many. Then, as they left, it fell to me to do more of the C-sections. Now other than Dr. Jones occasionally doing a C-section, I do most of the C-sections. So my practice has gotten a little more surgical. I went off and took the didactic so we added laparoscopic procedures so we could do gall bladder and some Gyn procedures. If I had my druthers, that's all I would do. But practically — to keep the clinic running, well, somebody has to see the folks that come in the door.

There have been some tremendous changes with medical techniques and diagnostic tools. One of the things I think would really impact a smaller rural area would be medical transportation. Do you pretty much take of what comes in, or do you care flight them? Or . . .

Well, we take of everything that we can handle. We don't do neurosurgery, so we still do transport patients. We kind of grew up with the University of Utah. They took their RMP money back in the 1960s, and working with Key aviation, they developed probably the premiere, and certainly the role model, of long distance transports. We're too far away to go with helicopter. You'd have to refuel in Wendover to make it here in helicopter, so that our transport out of here is fixed-wing.

We've kind of grown with the University of Utah, with the LDS Hospital as they expanded

into St. George. We use St. George quite a bit to go to Las Vegas, because there just isn't really satisfactory transportation or entrance to Vegas except for neonatal transport.

So, no, we don't do everything, but I do a fair amount of orthopedic trauma work and the particularly fractured hips. It really bothered me when I came here to think that any of these little old persons who broke their hip had a four-hour ambulance ride to the university or one of the Salt Lake hospitals, to where they get their hip fixed. I'm sure that had affected probably the mobility and maybe mortality. Certainly there was pain. So that was really one of the first things that we set out to do was to take care of hips. And I do a fair number.

Do you have an aging population here like so many other places?

Yeah, I think so. When Kennecott pulled out, the community withered down, particularly Ruth and McGill. Property values are such and our tax structure such, as we tried to change the legislature over the years, that many of these properties were very appealing to people, particularly from California. You could buy a little house for less than ten grand, and taxes every year were nominal at most. So a lot of people moved into these houses that were vacated by the younger families as they moved out in search of another place to earn their fortune.

We have the Care Center next door; it's one hundred beds, ninety-nine beds. Most of those there are older people, and they fall and they break hips and arms and other things, and we take care of them.

Did you work with the Elko doctors?

Well, Tom Hood and Hugh Collett were sort of like myself: far ahead of their times

in the communities as far as their amount of postgraduate training, the techniques and skills they brought.

You were on the Board of Medical Examiners from 1978 to 1982. One of the things that the Board discussed then was Continuing Medical Education. Many physicians did not want it to be mandatory; they wanted it to be voluntary. How do you feel about that?

Well, I voted my conscience in those days. I still feel that physicians working with organized hospital medical staffs get the CME. To make it mandatory, to provide the policing type activity that goes on, falls into what the Board does, anyway. We've got 5 percent bad apples, and I don't think that making any kind of rules is going to change those bad apples.

Being on the Board of Medical Examiners was a real eye-opener for me, as I've discussed with Rex Baggett and some of the ones that have come on since; they've had the same response. I thought all my colleagues were all very clean, reverent, and those other twelve things Boy Scouts were supposed to be — honest, trustworthy and all. Then I got on the Board and I found out that we had criminals who had done hard time trying to get licenses in Nevada, physicians who got licensed with no other thought in mind but to sign prescriptions so that somebody could get illegal drugs. It changed my perspective on physicians in general.

I came up with some opinions, what I consider strong opinions, which are not shared by too many, as to how the Board should be composed. It's not only policing action, but I feel part of their job is to help with the problem of the disparity of the distribution of physicians. As I say, that's not shared by everyone who is on the Board and has been on the Board or is a voting person

in the legislature, who are really the ones who have the final say.

What do you think they need to do to correct the disparity?

Well, I don't think they can correct it, but I think it's possible for them to be more supportive in this. After my visit in 1987, when I talked to them, they passed the rule as far as allowing physicians to come to rural communities with only one year of postgraduate training. The first person they choose for this was someone who had had one year of rotating internship, who did not intend to practice a broad range of family practice, and gave him the license. I thought that this demonstrated that, despite my thought that I had explained in clear detail, they didn't really understand what I was talking about.

My example of what was needed was a fellow who had been on one of the outer islands off of Alaska for twelve years after being AOA at San Francisco. He had done his internship at Virginia Mason, where he was rated outstanding by his training program. Anyway, he wanted to come to Nevada. Without three years postgrad, there's no way he could be licensed in Nevada. The Board wouldn't even talk to me about it.

Is that when you went and visited them in 1987?

Yes, and at that time tried to explain to them how this was creating a hardship. There have been examples since then of physicians who would consider coming to our community who couldn't be licensed. There was no way to seek a variation.

Because they don't have the three years postgrad?

Don't have those three years. I sat on the Board and listened to Dr. Maclean enough times tell me, "Turn them down; don't give them a license. Make them prove to you that they should have a license." Well, this puts us in a posture that I see repeated now relative to how the federal people monitor nursing homes and other things. They don't try to be helpful; they just provide a barrier. That's why I say there's no voice on the Board for the rural communities, to point out, to help them understand where the rest of the state is and how these things differ.

What's the problem in getting someone with three years of postgraduate training to come to a rural area?

Because they can go anywhere else and make more money. And when you're anywhere from sixty to one hundred and eighty thousand dollars in debt, that is a prime consideration.

What can you make in a rural area? Half as much money, three-quarters?

Yeah, probably that. I talked to Carolyn Ford and the people that were working on the programs that we have, some minor forgiveness, loan forgiveness programs. The problem is when the budget gets tied up in the legislature, they don't fund it. Many figure out ways to get these moneys, and then they won't stay in the rural communities. Little by little things may be improving, but, still, there should be a physician for every eight hundred people or a G.P. for every thousand people, and we don't even come close. Then the state takes away our designation as a health manpower shortage area, because nobody in the state government can bother to come over here and find out how many doctors there are

here. It becomes pretty much of a perpetual fight, and as we learn where the skeletons are hidden and all this sort of thing, we learn to play the game. Then we have another election and somebody retires, and then we have to invent the wheel again. All of these factors are disincentives.

We try to figure what probably works the best. In the late 1960s the University of Washington had a program where you take the kids from the rural communities, not just the fellows but the gals, who are going to be doctors and lab techs. You take them out of the big cities and send them back home every other year or something like that, so they remain oriented. Not all are going to go back but 35 percent of them are. If you look at the Jackson-Coker statistics for 1993, you see that 1-1/2 to 2 percent of students enrolled in medical schools were planning to go to rural communities.

There is no absolute solution. All you've got to do is go to Denmark or the Scandinavian countries where, you know, they have a socialized medical system. They have problems placing physicians in rural communities, even though money really isn't a factor when everybody is the same. Somebody who's got twelve to eighteen years of education really doesn't want to live out in the country. They want to be where there's opera and stage plays and shopping and these sorts of things. We are seeing it with the female physicians, where their husbands don't like the rural communities even if they do, so we are not really not recruiting one person; we're recruiting a pair.

Have you had any female physicians practicing in Ely?

Oh, yes. Kathy Coopersmith came back after she got through school, but her husband,

who was an accountant, just didn't fit in the community. That and the isolation. For a while another female physician was involved in the hospital clinic. She was pretty much just waiting to get her dermatology residency, and as soon as she got it, she was gone. We have a woman now practicing at the hospital who's been here three years. Her advantage is that when her husband didn't like Ely, she divorced him. She will probably be staying here. It's not easy, and she comes from a small central Utah town, so she cut loose and likes what Ely has to offer.

What do you think Ely has to offer from a medical practice point of view?

It offers the opportunity to practice the kind of medicine you want to practice; the opportunities are pretty much unlimited. I mean we don't allow family practice resident students to do neurosurgery, but if they're proficient in dealing in endoscopies or if they had some extra training in doing C-sections as a part of their OB training, if they know those things, they can do them here. And you can damn well be sure they wouldn't do it in Las Vegas.

It's an opportunity to be on the hospital staff and influence the rules on how we will do this. We have one of the two rural joint commission-approved hospitals in the state. I think that's kind of a mark of a pretty progressive and well-equipped hospital. We've got CT, mammography, and ultrasound and many of the things that larger facilities have.

Do you think, then, with the rural practice you have the best of both? Old-fashioned kind of medicine where you know your patients?

Well, yes, like you found when you talked to the deputy, everybody knows Dr. Chris.

When I came to town we didn't have a paging system. I happened to have a couple of unique vehicles, and one Sunday we were coming in with the kids. At the stop sign, a lady rolled down her window and I rolled down my window, and she said, "Say, Doc, they need you at the hospital." That wouldn't happen in a big city. And many don't want that. In this day and age the graduates don't want to be on call; they want hours and they want holiday time with their families and this sort of thing.

Doesn't make it a little harder to separate yourself from your work?

Oh, definitely. In other words, if you don't really like your work, then probably you are not going to work too well in Ely. If your wife doesn't like the fact that the telephone's kind of a pariah, then she's not going to like Ely. As I say, my wife's a nurse and she knew what she was buying into before we got married. She grew up in a small town in southern Missouri, so she knew what small towns were, smaller towns than Ely.

Does she work in Ely?

Principally here. We kind of struck a bargain when the kids came along: she would stay home and I'd work. I was hoping that then she'd start working and I could play around, but it hasn't worked out quite that way. Something about, you know, the difference between men and boys and the price of their toys, and I kind of have expensive toys.

In 1978, when Kennecott started closing down, we'd been here for ten years. We said, "You know, it looks like the old town is going to go. Maybe we should pull up here and go down someplace that looks a little better." We both thought about it for about six months and then sat down, and neither one of us

could think of any place other than Ely. My wife pointed out if I went anywhere else, it would be someplace just like Ely. So, much like you learn from the investment counselor, churning the account doesn't gain anything. She likes to see some green trees and a little rain once in a while, so we take her back to Missouri, but usually about five or seven days is enough and she's ready to come home. I visit Arizona and see the urban blight down there, and I'm usually ready to come home in forty-eight hours.

Even when the temperature drops to twenty and thirty below in the winter? [laughter]

Oh, we love the winter. In fact, we look forward to the winter; skiing and outdoor activities in the winter are our oyster. We don't get enough of it. Last winter was terrible when the skiing wasn't good. The year before we'd drop our skis out the back door, and we could go cross-country as far as you wanted to. Come back if you still had the stamina. We have horses and race chariots.

You race chariots? Like Ben Hur?

Well, no, not really like Ben Hur. It's gotten pretty modern; the chariots are made out of aluminum, fiber glass. I've raced mostly Appaloosas and they'll do a quarter in twenty-four or twenty-five seconds.

Where do you do this?

Out at the fairgrounds, or we used to have to haul to Wells because we didn't have enough to have a club here. Wells has the only club in Nevada.

It's a good place to raise kids, you know. Everybody says there's nothing for kids to do. Well, summertime around my place my kids

were tired enough; when the sun went down they went to bed. They had their animals; we raised hay and hunted and fished and that sort of thing.

Generally when we look at things for recruiting somebody, if you've got somebody who doesn't like the outdoors, they probably aren't going to like it in Ely. If the library and the opera house and these sort of things are your bag then it's going to be a little tough. We got a community concert, so we get three or four functions a year. If you like to sing, play instruments, we got a community choir and the churches — 45 percent of the population is LDS, and they, of course, have their family orientation in the way the church functions.

One of the issues that you have dealt with when you were on the Board was midwifery. Do you think that has a place in rural health?

I guess so. We've got one upstairs. She just called in this morning; she passed her national boards. Dr. McHugh sponsored her.

We licensed and set up the regulations for P.A.'s when I was on the Board. I resisted it. I was against it. But we got a P.A. upstairs. Well, as originally proposed, it was, you know, to kind of take care of this gap while medical education caught up and we were going to have doctors. There wasn't going to be any place for P.A.'s when they got through. Not all of those predictions have come true. But having had opportunity to visit and get to know professionally some of the P.A.'s and their experiences and the practice opportunities they have been involved with — I didn't feel what they were doing was productive and probably contributed to what now is part of the national travails as far as restructuring the way we practice medicine. As I say, I only gave in when it got so the physicians were so few that there really wasn't any other solution.

I really don't know how it's going to work. The school is going to take in a program with the slots in Washington. Cal Henley was the first one of our people and, as far as I was concerned, a good candidate. He already had an undergraduate B.A. degree, and he had earned an associate degree while he was working in the local labor community, the mines and the local lumberyard. He got an associate degree in computer science before he went to P.A. school.

We have another young fellow who grew up here. Larry and I have been trying to get him in medical school, but he just wanted to set his own pace, so he's been accepted. I may recant a little bit on my original feelings from 1978 to 1982, but not totally, you know. They may fill a place, but upon being given the choice between the family practitioner and a P.A. I want the family practitioner. There's more that they can do than a P.A. because of their training. This is not to say there are not some good P.A.'s. We have a couple of real good ones at the present, but it takes the individuals attuned to these sort of unique situations. We qualify for all the federal programs as far as rural health facilities are concerned, because we do have midwives and P.A.'s to work with us.

So midwives are just starting, and the jury is still out on them?

Yes. The community sponsored her. She was already an advanced practitioner before she went into the midwife program through the University of Utah.

It is my understanding that liability insurance for OB/GYN is so high that a lot of G.P.'s have gotten out of that. Is it the same way with the midwife?

Well, I don't know about midwives, but it's made it difficult for a rural G.P. to do OB. They really have to believe in it as part of a general practice because financially it's a loss. There's just no way to make it pay; liability's about forty-two thousand per year.

Of course, they've been hitting me for that since whenever, because I've been in the top bracket all along as I do C-sections. And I do surgeries. And I do some orthopedic trauma. All of those are on top. I've got to make forty-two thousand dollars before I get any. And you figure I have to probably pay close to one hundred thousand dollars in overhead to turn on the lights, to keep the computers running, have the girl at the window when somebody comes in. It's pretty daunting to somebody who's in hock for a hundred grand to think about taking on that kind of load just to be free and independent.

What about homeopaths, naturopaths practicing in the rural areas, or practicing, period? That's an issue that the Board has dealt with.

Well, I think the Board did very well with homeopaths. If they want to get a homeopathic license, then you can practice only homeopathic medicine. Naturopaths, of course, I don't think have any place; I think they're totally a cult. Chiropractors have tried to get respectability and as long as they weren't recognized by any educational accrediting body, that pretty much took care of that. After they gained "legitimacy" in 1982 or whenever it was, that's a different bag of worms. The osteopaths and their schools still do teach manipulation and those sort of physical techniques, as well as allopathic techniques. The osteopaths, as Les Moren would say, "Those ten-fingered osteopaths," [laughter] which is how you referred to those who trained before 1968.

In California, of course, they tried to do away with their osteopathic schools and licensing. The osteopaths who were practicing resisted that; not all of them, but a good number of them. The board was reestablished, but then they started a new osteopathic school, now the Osteopathic School of Pacific or whatever that figures out to be. UC Irvine used to be an osteopathic school before the big change in 1968.

Osteopaths are pretty well equivalent to the allopathic physicians except for the fact that their board has not been willing to go along with our Board as far as the three years of postgraduate training. If you're an osteopath and you take one of their accredited programs, you can be licensed to practice in Nevada having one year rotation. Going into a rural community with one year rotating internship probably isn't adequate. I don't know that formal training is all that important, but experience is important.

This is what I tried to discuss with the Board, and, of course, because of the legal implications, they don't really want to have that. I already talked to the counsel to see how cautious he is about having the Board liberalize in any way their criteria for fear someone else is going to come along and say, "Well, you granted this guy" So that they pretty well stuck hard and fast to the rules. I've talked to Bruce Bannister, who is now the executive of the osteopath board. Being an M.D. residency-trained physician who is an osteopath, he can see the problems that many of us have had with the one-year training and osteopaths' independent practice in rural communities. Maybe this next legislative session that will be changed. I can tell you from the point of view of the leadership, the medical association will probably not enter into that fray very heavily, because our major goal, push, this session is going to be for

tort reform. If you are going to face off with attorneys, you're going to have a lot of money and you're going to have to bargain.

We talked a little bit about the politics involved in the Board. Why did you go on the Board when you were offered an appointment?

Well, I knew that Dr. Anderson had been on the Board, and I can't remember who the governor was, whether it was Sawyer or O'Callaghan. When his term was up, there was a lot of pressure from the Clark County people. Of course, they weren't as numerous in 1976 as they are now. They couldn't exert enough pressure, so the governor gave that slot to Clark County. Dr. Moren's slot came up, and the Elko Clinic had not pleased the governor.

How did they displease the governor?

Because they would not sponsor a physician's assistant in Wells. He felt it was on the basis of principle, but it was based on their knowledge of the quality and qualifications of the person that was to be there. As far as I'm concerned, that's the way it should be. That's why I was appointed. And then Governor List felt further pressure from Clark County; because they do have all the juice, they should have all the votes. I was replaced by someone from in Clark County in 1982. From that time until Dr. Snider was appointed, there was nobody from any place besides Reno and Vegas on the Board. Then the governor decided that Carson City was rural enough that someone from Carson City was appointed. But there's been no representation from the great body of Nevada since 1982.

Who applies the pressure, then, from Clark County, the medical society?

Yeah, and the individual physicians who want power. Generally, they've made generous contributions to the campaign of the governor. I know when the first lay person was appointed to the Board he told Governor O'Callaghan, "I want that job." The old patronage system seems to be the political norm. When you got thirty bucks a meeting plus the travel, it wasn't really a lucrative position that you were seeking. The physicians did it as an obligation; that's why I did it. It sure as hell wasn't convenient for me to go up there, when we were just down to three physicians, and to spend one or two days in Reno or Las Vegas. But that's what it's become — political. On the average with some good leadership their activities have not been bad — they haven't been helpful to the rural communities.

What would be an alternative way of building the Board other than as a political appointment?

Well, I don't know that there's another way. Having had the experience of being on the Board and visiting with other states, as is often the case, you come away from the meetings and realize that it is probably an imperfect system, but it certainly is not as bad as the one in Maryland and Massachusetts, or whatever particular venue you want to compare us to. It would be nice if the names that are suggested by the Medical Society were given a little more weight when these appointments are given out. The doctor who replaced me was not a member of the Medical Society, and he had no idea why he was selected to be appointed to the Board. He didn't ask for it. This is not to say we should make the Medical Society omnipotent, but generally they are aware of the physicians among the rank and file, are aware of the practice in communities.

We got to a point on the Board where there were all pediatricians. Pediatricians really don't know what surgeons do. To not have that part of the specialty and panorama represented — it didn't work very well. However, when you have someone of the quality of Tom Scully — he sure as hell knew where a surgeon was to ask his opinion if he had a question. Not all of the people on the Board had the insight or spent the time for this not very munificently paying job.

Would you go back on the Board?

Probably not. Principally because I don't have that much spare time. The kids are raised, and you really ought to have some more spare time. But there are a whole lot of things I want to do. I think probably somebody new, much as Dr. Baggett and I have discussed, needs to experience what the Board does, a broad cross section and panorama of our physicians that are coming to Nevada. But as my wife will tell you, don't have to twist my arm very much and I would give in. It's not a very rewarding job. I made some good acquaintances that I still try to keep up. But it wasn't one of the more pleasant jobs that I had to do.

Because of dealing with the physicians? Not the ones you worked with, but the ones that were being investigated or chastised?

Investigated and disciplined. One of the physicians whose license I took away now practices in this community. This doesn't make things very pleasant because in these kinds of communities, you can't hide from them. Our CME sessions are altogether.

Did the physician stay around here after he lost his license?

No, he came here to prison. It's another one of the actions of the Board which I followed with interest, and Dr. Scully and I discussed in the bar after meetings, how it turned out. Again, it's an extension of how the system isn't perfect. And how, though we're castigated by the federal government and everyone that we aren't tough enough, whenever you try to be tough, you're going to have a bad situation. That person always has access to the legal system, and they will foil you.

Over the years the response of the Board to substance abuse has become much more formal, with treatment rather than punishment. Do you think problems that physicians have had with substance abuse are more prevalent now because of the pressures? We're more aware of it? Do you have a feel for this?

Well, you know, I think one thing we have to look at is how many more doctors there are; I don't know that anyone has pulled these numbers up to know. I would add to the reasons you point out: is that with the public, as also in the profession, folks are more understanding, more forgiving, more open. Those things were kind of brushed under the table and covered up. Now, it's all right to say, "I'm an alcoholic."

The State Medical Association has helped, I think. They spent a lot of money that the Board didn't have to spend setting up the committees on both the north and south part of the state to deal with these problems under Dr. Scully's leadership, I guess you would say. They've been given help and support from the Board, so that these physicians can be counseled, can be monitored, and these sort of things which are available. I know some very good doctors who have been salvaged. I know some doctors that possibly I wish we

had been a little more strict with, but, again, a doctor always has an attorney or attorneys who will somehow manage to foil the Board — or not foil them, but, you know, muddy up the situation up to where these people continue to practice, even though they are impaired.

A doctor writing about medicine in Nevada in 1944 was concerned about the loss of skills and techniques among physicians, that they weren't observant. Dr. Moren commented that a lot of physicians are so busy and medicine's becoming so impersonalized that you don't listen to your patients anymore; you don't simply look at them. He was talking about percussion. He said he didn't know if they even teach them how to do that anymore. What do you think about that opinion? Has it changed in medicine?

Oh, definitely. I couldn't agree with Les more. A recent physician we had here told the girls out front, "This patient will have this lab work, and it will all be done in my office before I see the patient." That technology has gotten between the patient and the physician. I think that's most of what we're hearing in Washington, what everything is all about now.

The system has come between the patient and the physician. I mean when the physician went by the house and diagnosed the tonsillitis, and he was paid in two chickens: that was personal. The person who raised the chickens had a personal involvement in how the payment came about and this sort of thing. Now that patient's parents take him to the emergency room, where he is seen by a physician who is on a salary, and this much lab work is obtained, and it costs them five hundred and eighty bucks. We see this, and I catch myself, try to discipline myself not to do that. You should touch the patient; you should greet the patient and sit down, you

know. They don't sit down anymore; we don't need chairs in examining rooms because we're bing, bing, bing, bing. I see this as a complaint. These patients come back from Salt Lake City and say, "I saw him, but, you know, I didn't get to know him. I mean he punched some numbers and stuck some needles in me and charged me five hundred and eighty bucks."

These are parts of medicine that exist today; it's grown so big. As I said, my wife was kind out of the circle for a while until she came back to work here, and she said, "You're using all new medicines. I mean these weren't the medicines we used in 1966," which was the last time she worked at the Sandia Base.

Medicine was involved and technologies have gotten greater — they've lengthened postgraduate training but medical school is still four years. There has become more and more emphasis on technology and less and less emphasis on patients, which is not to say it was always good. When I went to school, Dunlap, Poplar, and Linden ran east and west in Memphis. The administrative offices and the basic science buildings were all over here. The hospital and the clinical stuff was over here. You had to be a junior before you crossed over the streets. These kids from Nevada think I'm blowing smoke when I tell them, "It's great! You get a tutor, and you see patients in the office when you're a freshman." It allows them a chance to see where it is where we're going. Not just a corpse in anatomy lab, not just a mouse in physiology, but real people.

To find out before your junior year if you like people?

Yeah, if you like people. My daughter, when she was graduating from high school, said, "You know, Dad, I know you want one of us to go into medicine, but," she said, "I don't like people that much." She's going to vet

school now so she's going to learn about that. That was her choice. Let her find out herself.

Well, if she doesn't like people . . .

All those pets have owners. She's smart not to go into pediatrics. If all those kids didn't have parents, it would be pretty interesting just to practice pediatrics. But all those kids got parents.

One association often made with medicine relates to the dignity of the profession; preserving the dignity; preserving the integrity of the profession. What do you think about that? About the physician as God, the physician as perfection?

Well, it exists. It happens. There are a lot of people who want a paternal figure and we see this particularly in the older ethnic populations. They come to the doctor and what he says, that's the way it goes. This goes back to when the general manager was God around here, and Mr. Kinnear said, "This is the way it's going to be," and that's the way it was going to be. So if the doctor says that, that's the way it should be.

Our twelve to eighteen years of postgraduate education has put us in a unique position that not all the individuals who become physicians and go through this training program are willing to accept. It's maybe not just physicians, but maybe allied health professionals. People kind of like you, and if you've got long hair and a beard and you wear ragged jeans and a sloppy shirt or a scrub top, it's not exactly the image that most of the rank and file have of how a physician ought to look.

These are some of the individuals who are coming through our training programs. You see this at a graduation, and I've gone to a few

of late. My daughter graduated from Carleton, and my son graduated from West Point, and my son graduated from UNR. My daughter is going to graduate from Davis. We might have all thought the hippies were gone, but if you've been on a campus recently, there's a few of them left. And they're not just in vet school; they're in medical school, too. So that I don't know where that goes. Certainly that's part of what Slick Willie and his consort are working on in Washington as far as taking some of that mystique away from doctors; getting them down off their high horse.

More warm and fuzzy?

Well, yeah. They don't care if you are warm and fuzzy; they just don't want you to be that God image. I've got a joke on my locker about the fellow who cuts in line at the cafeteria at the hospital, and this doctor said to another, "I thought we had gone to heaven, and I thought that nobody had special privileges up here." And the other doctor said, "Well, that's God, and sometimes he thinks he's a doctor." [laughter] That's why I think every physician ought to have an operation.

Would you go into medicine again? Has it been what you expected more or less?

I wanted to be a vet really bad. I don't tell my daughter about this too often, but I'm living vicariously through my kids. I'm a private pilot. My oldest son is a professional pilot. My daughter's going to be a veterinarian; my youngest son's probably going to sell Eskimos iceboxes, so I don't know where he fits in to all this. I thought he'd come back and raise hay for me, but he hates it.

I was discouraged by this doctor I told you about from going to vet school. When my mother told him that's what I wanted to

do he said, "Don't waste your time being a veterinarian; go to medical school." After I watched him operate on my colt, it looked like a pretty good idea to me. I do a little bit from time to time, spay a cat and sew up a horse.

I can't complain. I haven't made as much money as my roommate who practices in Sonoma, California, but then I'm still married to my wife, and I still talk to my kids. So it's sixes and sevens.

JOHN CREAR, M.D.

Dr. John Crear is a native of Texas, and was raised in Houston. He attended Prairie View College for three years before joining the army. After his military service, he returned to Prairie View and earned a Bachelor of Science degree in 1947. He received a degree in Medical Technology from Meharry Medical College in Nashville, in 1949.

Pursuing a lifelong dream to become a physician, Dr. Crear entered medical school at the University of California, Irvine and received an M.D. in 1966. He moved to Las Vegas and entered practice with Dr. Charles I. West in 1966. He established his own practice in 1967.

Dr. Crear has been active with the National Medical Association and was one of the founding members of the Las Vegas chapter. He is also a member of the Clark County Medical Society and the Nevada State Medical Society. Dr. Crear was the director of the Chemical Dependency Program at the Community Hospital of North Las Vegas, from 1977 to 1986 and has directed the Chemical Dependency Program at Lake Mead Hospital since 1986.

John Crear, M.D.: I was born in Bryan, Texas, but I was raised in Houston, Texas. I have no brothers or sisters. My mother taught school in the Houston Independent School District for years until she retired. My father was a foreman at the Longshoremen in Houston, Texas. He worked there for many years until he retired. I finished high school in Houston, Texas, and then I went to Prairie View College in Prairie View, Texas, for three years. I went into the army for two years.

I came back to Prairie View for one year and graduated with a Bachelor of Science degree. I was interested in going to medical school, but did not get in at the time. I applied for medical technology, and I was accepted at Meharry Medical College for that program. After two years I completed that program; then I returned to Houston, Texas. I worked there in a private hospital and the VA Hospital, before going into medical school.

Anita Watson: Did you always want to be a doctor?

All my life I wanted to be doctor. I used to deliver papers, and there was a doctor on my route. He really impressed me. I wanted to be like Dr. Jones; I wanted to be a physician. At the time that I applied to medical school, they only had two predominant black medical schools, Howard University and Meharry Medical College. In those days you had to have real high averages. When I was not accepted, I kept on trying to be a physician. That's the reason I went into medical technology — so I could stick as close as I could to medicine.

I applied to a school in California and was accepted. I just stopped everything and went to school.

At the time that you were applying to medical school, was it more difficult to get in because you were a black person? Would you have to go to a black medical school?

You mean in Texas, where I was? They began to take a lot of black students, and I almost got in. But I was accepted in California. When I first started going, there were three blacks in my class. Then the first year we lost two of them, and it just left me. The next summer they picked up another black student. Later on it opened up.

You went to medical school at U.C. Irvine?

Yes. When I first started going to school, it was an osteopath school. I was really happy there, and I was doing real good. All of a sudden with my class they decided to convert us to get M.D. degrees. Ours was the first class.

How did you feel about that?

I was satisfied with the D.O. I had something that a lot of people didn't know

about — you know, it was growing, and I really felt good about it.

I interned at the L.A. County General Hospital. Later the school moved from L.A. to Irvine, and became a part of the University of California, Irvine, School of Medicine. See, Irvine did not have a medical school. But they took that school and moved it.

How did you feel about medical school at the time?

I enjoyed it. Everybody was nice to me. They made sure that I got everything I was supposed to get. See, I'd been out of school for so long. The first year it was kind of hard, you know, because I had to get back in the swing of things. But once I got back in the swing of things, everything was fine.

You'd worked a long time to get there. How old were you when you went to medical school?

I graduated when I was thirty-something.

Were you the oldest person in your class?

No, there were some older than me. Oh, yes. Some were optometrists; some were dentists, and some had Ph.D.'s. It was really a challenge; they were so smart . . . a lot of Ph.D.'s in the class and masters. Everybody had a degree, I think.

After you finished medical school you came to Nevada.

Yes. I was planning to go back to Texas and practice. When I was an intern, I thought I would go take the Nevada board because they would reciprocate with Texas. It seems like California didn't. So I came to Nevada to take the board. While I was in Reno taking the

board, after writing the answers, they asked you to come back for an oral. They asked me, "If you should be looking to pass this board in Nevada, where would you practice?"

I was there in Reno, so I said, "Well, I'll practice in Reno."

Somebody said, "Why don't you go to Las Vegas?" During the break, when I was talking to the people on the Board, Mr. Neff — he was the, I guess you'd call him the executive director — he said, "Ever heard of Dr. West?"

I said, "No."

"Dr. West is a physician in Las Vegas who has been trying to find a doctor to come practice with him. Why don't you write him, and see what he has to offer, what he has in mind, you know?"

So I said, "OK." I went back to L.A. I got a letter in December, and it said I passed the board here. So then I wrote Dr. West to tell him I was coming to Las Vegas. He was very, very happy. He called me on the phone, "You can come to Las Vegas. You can work with me, or you can work on your own — whatever you want to do. I will help you get started."

Dr. Charles I. West. He was the only black physician in Nevada. So I told him, "I'll come down one weekend."

He told me, "If I'm not there, I will be in Carson City or Reno having a meeting with the governor. But my family will be at the house. Go to the house, and make yourself at home. When I get back, we'll talk." I'd say he was a very important man. He had a newspaper here, and he was in politics. He was very well known, and he was a very nice young fellow, nice person. And he was a good doctor, too.

So we came down, my wife and I, that weekend. I wanted to see what he had to offer. He said, "Why don't you come here and work with me? I'm by myself, and I need somebody."

So we decided we would go ahead and stay awhile and just see what was going on, see what was happening. I worked with Dr. West, but he did not work long, only part-time. He was semi-retired, I guess. He only worked four hours a day. I said I had to work more than that. I stayed with him about six months. We had a good relationship; couldn't ask for any better.

I decided to open my own practice after about six months. Everybody here in Las Vegas was so receptive — all the doctors were so glad to have me. The patients and people were so nice. I decided not to go back home to Texas, to Houston. That was 1966.

What was family practice like when you first started?

One thing, it was a lot of work. I tell all our doctors now, "You come to Las Vegas, you got to work. You can't be lazy. There's work for you, but you got to keep up. You got to do it, you know." When I came here, I worked at UMC, but they called it Southern Nevada Memorial Hospital then. We would be on call in the emergency room, maybe two or three times a month.

When I was on call, you can get patients, patients, patients. Within half an hour you can have fifteen patients at one time. It was just going, going! I had no problems with anybody. The other doctors here — they were so nice to me. They would take my hand and say, "Need anything?" Or, "Call us."

I was delivering babies; I was doing everything. Just anything that I felt I was able to do. If I had problems with an OB, I called an OB doctor. They had a surgeon on call, orthopedic doctor on call. My wife was in the Clark County Medical Auxiliary. Everybody was nice to her and nice to me.

You were active in the National Medical Association.

Oh, yes. The National Medical Association — that's mostly black physicians. It's real large, you know, like the AMA. See, a long time ago a black could not join the AMA, so the blacks started the NMA — National Medical Association. It went along for years like that. It's still very prominent, you know. I would go to the NMA convention and try to get people to come to Las Vegas. Doctors. "Why don't you come to Las Vegas?"

They would say, "I'm not coming to Las Vegas; I'm not coming to Las Vegas."

"Why?"

"I don't gamble . . . I don't gamble." And, "Do you have any schools, there?" "What do they do there?" You know.

"Come. Come and see," I'd tell them. I'd go to the convention every year by myself. Then they all would come around and ask questions about Las Vegas. You had to have seven doctors to start a chapter. For a long time nobody would come here. Then, all of a sudden, they started coming — we had one, two, three, four. When we got seven doctors, we started a chapter here. That was about 1979.

You were the founding president?

Yes, yes. The founding president. And it's growing now.

What did the local chapter of the National Medical Association do here?

Well, our main point was a scholar's program. They were trying to get black students in the University of Nevada Medical School. They didn't have any black students, you know, and they did have one of the members of the society on the admission committee. I think it was Dr. Ice. Then they had Dr. Neyland on the admission committee.

The school was very helpful. We worked closely with Dean Daugherty.

The National Medical Association had a program where they would send letters to all the high schools in Las Vegas Valley; asking kids interested in sciences to apply to go to this scholar program. The teachers would interview students down here and up north. Then, once a year they would go for a week to the medical school in Reno, and they would come down here a week — trying to find youngsters who were interested in medicine. They're still active in the scholar's program.

Do you have a number of black physicians practicing in Las Vegas?

They are coming in so fast now, I don't even know them. In the old days, when they would come, most of them would come look me up and talk to me. I'd tell them things about where to go, how to get along, and about the hospitals and everything. But now they're coming so fast, I don't know they're here.

Were you on staff at both UMC and Sunrise?

I wasn't on staff at Sunrise. I was on at Women's Hospital. And at UMC. I'm on staff there now. See, the town's gotten so large now I do it for in-town. I just go to UMC, Valley Hospital, and Lake Mead Hospital. I'm part-time there.

I'd go out there mostly to assist in surgery in the old days. I call it the old days. They would call me to help out.

Who all did you work with?

With Dr. Delee — Sol Delee. And Dr. Rojas and Dr. Vickstair. Those are OB/GYN doctors, and a surgeon I worked with. I also worked with Dr. Nellor. He passed away,

but he was a surgeon. There was also Dr. Christian. I worked with him.

You had some involvement with the Board of Medical Examiners because of problems with substance abuse, chemical dependency. The Board's involvement with that started in 1973. Can you tell me when you first started having problems, and what kind of problems you had?

Let's see. When I first came to Las Vegas, I was working a lot of long hours. I was trying to do so good, you know. I would get to work, and I would start drinking. I'd buy a small bottle of Scotch, and I'd take a drink on the way down there. I never got into trouble or anything. But you see, alcohol gets progressive. You want more and more. I didn't realize, you know. I was drinking on weekends, and it got so I was loaded every night.

Was this to relax because you were so tired, or so stressed, or . . . ?

Well, what really happened, I didn't have any hobbies. Really, I didn't have anybody in Nevada to talk to much. It was just my wife and I. But I didn't realize I was drinking that much. You never realize that, see. I found that I was drinking more. And then I decided to get help.

My wife, kept telling me that I was drinking too much. I would hide it, see, so she really didn't know. I was hiding it. I started going to AA. I did not go for myself, but because my wife wanted me to go. I wasn't sincere. I would come back home, and I would drink.

Was this because you didn't realize yet you had a problem?

I didn't realize it; you never realize it, you know. I kept seeing my patients every day,

and I wasn't in trouble or anything. What really got me, finally, I was slow. I was trying to be careful. It might take me longer to see one patient. I wanted to be sure I didn't make any mistakes.

Is this because of the drinking?

Yes. And then, like I said, I went to AA. Someone told me I should go see a doctor. So I went to see a psychiatrist in town. To find out why I was drinking, what was wrong with me. It was Dr. Schwartz. He has passed on now. He told me that from my history, I needed daily care; I needed in-patient care. He knew of a banker in town that went someplace in Minnesota, a place by the name of Hazelden. We made arrangements for me to go.

It was pretty close to Center City, a few miles outside of St. Paul, Minnesota. My wife went with me. It was a thirty-day program. At the end of thirty days, they didn't call my name — with the graduates, you know. I said to them, "I'm ready to go back to Las Vegas now. I'm through with the program."

They told me that I wasn't ready. In the program you had counselors, and they told me, "We cannot make you stay, but we think you need to stay longer."

I said, "I've got to go back. I've got patients waiting on me."

They said, "No, you should stay. If you stay one week, one month, but you should stay."

That's the reason right now, I believe a lot in counselors. They could tell I was there a whole month — just marking time until I finished the program to get to leave. I wasn't that sincere. And the counselors recognized that. My wife told me, "Don't come back home. Stay there."

I called my uncle in Texas. I told him, "I want to come back home"

He said, "See if they can do anything for you. They say you need to stay."

I said, "Here I am. I'll just stay." So I stayed about three or four weeks longer. And that really did do it. See, Hazelden is a renowned treatment center. They have doctors there, preachers, teachers, and everybody — movie stars. I stayed longer; I haven't drank anything since then. Not since 1973 — that's over twenty years.

One thing I have to say that really helped me out while I was there, I received a letter from Dr. Rydell. He was the president of the Clark County Medical Society. I was surprised I got a letter, telling me that they were pulling for me. They said that anything I needed, let them know, and they would help. When I came back, he would do all he could to help me. They really helped me out. I will never forget that. I was really depressed when that letter came, out of the blue. That really pepped me up and really helped me out — to know that they were behind me, see. While I was gone, my wife was pretty discouraged, you know. When I came back to Las Vegas, everybody was so glad to see me.

I didn't pay my yearly fee to the Medical Board while I was gone. So then they wanted to know what was happening to me, and they found out I was being treated. When I came back, the Board wanted to see me. I had to go to Reno; they wanted to talk to me. I don't think they really knew what to do with me. In those days they didn't know what co-dependency was. It wasn't like it is now. Now they have the impaired physician program to help doctors.

I went to Reno, and talked before the Board. They said, "We're glad to have you back. We need to get you a doctor; to get a letter from the doctor, saying how you're doing in a month." So that was that. They said, "We didn't take your license, aren't going

to take your license. You didn't do anything wrong."

I got a doctor. The next time the Board met in Las Vegas, I went. I got there early, and one of them was there. And he said, "How you doing?"

I said, "Fine."

And he said, "We're really proud of you. We didn't think you were going to make it. Most doctors don't do it. We are really proud of you." And he said, "Just keep on going. You've been in AA?" He was the only one who said that.

I said, "Why are you picking on me?"

It just happened that I got there early. He was the last guy out, and he said, "I want to talk to you." I don't know if he was a recovered alcoholic or what. But he said, "I'm really pulling for you, and I think you're going to make it. You have surprised all of us, but we're proud of you."

The Board, at least in your instance, was helpful simply because of their support?

Very helpful. And I never will forget the letter from Dr. Rydell. I was way off in Minnesota, didn't know anybody, by myself. I didn't know how I was going to make it; whether it was working or anything, you know. And all of a sudden I get this letter from the president of the medical society. In those old days, see, I was ashamed. Do I want to admit it? And they tell me that they are still wanting me to practice, and they want to help me.

When I came back to Las Vegas, I worked at Southern Memorial Hospital. They said, "Don't work in emergency room because that would be probably be too fast for you. Why don't you go in out-patient department?" I worked there for a few weeks; then got back to my own practice. The doctors were just

nice to me. I couldn't have made it without the other doctors here. It was all races of people, all nationalities, but I never had anyone say anything about me. They were all just glad to see me.

What happened with your practice, then, when you were in Minnesota? Did you have to shut down?

Yes. My wife closed the office down and put all my stuff in storage. Then when I came back — see, a lot of times you got to make a change, you know. I wanted to get a new start. I found an office over here on El Rancho Lane.

Where had you been practicing?

I was on West Bonanza, West Las Vegas. I had patients in line; I didn't take a break. I went to work at ten in the morning, no lunch break. I worked straight through and didn't get home until eight o'clock. The patients just kept coming, coming, coming, coming. I was just working, no off days. I enjoyed it, but I started drinking at night.

When I came back, I put an ad in the paper that I was back. All the patients started coming back. They said, "We're glad to have you back."

So did you get really busy again?

Yes. But like now I'll take a lunch break, like right now. I work from ten to one. One to two I close. Then I work from two to five, and then I'm through. Sometimes I'm open all day Saturday, and close Sunday and Monday.

You're not carrying the load that you were before?

Yes. Right. Another thing in the back of my mind, see, it might seem kind of strange,

but I wanted to do good; I didn't want anybody to say anything about me. I wanted to make sure I did right. I knew what I was doing, but like I said, people talk about all the doctors, and I didn't want anybody to talk about Dr. Crear. I hate to sign a death certificate; I want everybody to live. I realized that I had done all I could, the best that I could — some people aren't healthy and can't be helped, you know. I was just happy doing my work. But I didn't have any hobbies. Didn't do nothing.

Do you have hobbies now?

Yes, I do, I do.

So it's a little more healthy lifestyle?

Yes, right.

Do you think it was an added stress because you were a black physician, the second black physician in this state?

I put that on myself. I thought that, "I'm the one." I thought I had to do good, because if I messed up, they probably wouldn't get another black doctor in. I put stress on myself. I was trying to be good, to make a way for other black physicians. I didn't want them to say, "We had a doctor here, and he messed up." Then they would be careful about getting somebody else. But they weren't thinking that about me. They were always trying to help me.

See, my problem was, I was kind of ashamed, you know. When I came back to Las Vegas, I didn't have much money. I wanted to get a new office. I went to a bank on West Charleston to get a loan from the banker. And I was sitting there, talking with the banker. And he said, "Where have you been?"

I said, "Oh, I've been sick."

He said, "What's wrong with you?"

At that time it was somewhat different, you know. So I said, "Well, I'm an alcoholic."

And he said, "How much do you need? I'm an alcoholic, too." He said, "What do you need, sir? What do you need? Just go to AA, and you'll be all right."

I found out that day, alcoholics are everywhere. We would have a meeting of professional people, and I would find more people, alcoholics. That's how I got interested in the chemical dependency field. I want to help people. It's an illness, and I caught myself in time. The main thing — you got to admit you got a problem.

When I'd been back a few months, about a year, maybe, at that time one of the biggest treatment programs in the country decided to come to Las Vegas. They were going to put a program at the Lake Mead Hospital. I interviewed for the job, and they chose me to be the medical director. At the start, we had about four or five patients. It grew and grew, and now the care unit has a big place out on West Charleston.

When they had a meeting for all the doctors, I would go, and I got involved with a lot of the people who study chemical dependency. I consider myself an expert now, you know, in that field. It's really big now, and a lot of doctors send patients to me for consultation. Right now I'm the medical director of Nevada Treatment Center, Las Vegas. I'm still the medical director of the chemical dependency unit at Lake Mead Hospital.

Do you think that the help that you got, the fact that you went into treatment relatively early, was somewhat unique for that period of time?

Very much. It really was.

You mentioned the Impaired Physicians Committee . . .

I'm on that now. They have a southern unit and a northern unit. I'm on the Impaired Physician Committee for the Clark County Medical Society. If they find some doctors who they think have problems, they report it, and try to get help before it gets to the Board. The Board, I think, is very happy. They have an investigative committee, but we investigate and do leg work, too. It worked out real good.

But in my time I didn't have anybody — just me. And, like I say, I want to thank the Board; I really do. They wanted to help me, but they just didn't know how. What they did was right. They told me to get a physician to monitor me. I got a psychiatrist to check, to see how I was doing and everything.

It's real tough now. You got to have a contract; the doctor has to sign a contract. They have a monitor, and it's real strict.

Do you find it easier to treat people with chemical dependency because you've been where they've been, and you understand?

I do; I really do. That's the question that people ask all the time. They say I could have been a counselor. I think you can learn it. It helped me because the chemical dependent person, they're really sharp. They have all kinds of excuses, but I can see right through them. That helps me in my practice — like prescribing tranquilizers and prescribing pain pills. That kind of thing. I prescribe so much, and I don't want anybody to become addicted.

Do you take special care, do you think, to make sure that your patients aren't over-prescribed?

Oh, yes. And I'm thinking about myself. I take a lot of time with my patients. I don't like to rush them. Everybody says I'm too slow, but I don't rush in and out, in and out. I enjoy it, and when I leave my office, I know

what I did to every patient. They can talk to me. I think the history's important, getting a good history. A patient comes in, find out what's their problem! "How long you had a headache? When does it hurt you the most, day or night? Have you had your eyes checked lately? Do you have a sore throat? When did it start?" You know, a good history. It's very important to me, and when I examine you, the history just makes it easier. I don't like to rush.

Significant improvements have been made in dealing with the impaired physician, in early treatment, early diagnosis?

Yes, right, yes. I'm really committed to it, and I keep saying, "It's an illness." I look at it like a patient having diabetes. You know, people don't want to admit it. With patients I say, "Check your urine with a test tape, and see how your sugar is, and know how you're doing." OK. You might test your urine for sugar every day, and negative. No sugar. You might do that for six months. You say, "Well, the sugar's gone. No more diabetic. I'm well now." But what it is, the diabetes is under control with the medication or the diet, or whatever you're doing.

The same thing with alcohol and chemical dependency. Like myself, see, I'm a recovered alcoholic. I will die an alcoholic, but I'm not going to die from it, you understand? It's under control, but it's there. I could drink again, but I know I'm an alcoholic. I cannot control it. I don't want to try. I'm under control, just like a diabetic. Follow the directions, and you'll be OK.

Alcoholism is an illness that can be controlled but not cured?

Right, right. Under control. Like if I might, say, take a drink. Nothing happens.

Take another drink. Ah, I can drink all the time; I'm doing fine. And then maybe the third time, I can't stop. It's there. You may go a month, but it's there. The alcoholic cannot control it.

This is a big field where a lot of people can benefit. I treat a lot of people with cocaine abuse. With cocaine, most of it's psychological. It is one of the most addictive drugs in the country today. You want more and more and more. More and more. Once you start, you want to keep going. I treat a lot of heroin addiction with methadone. It's a big field.

With other chemical dependencies or substance abuse, like the cocaine or heroin, can they be cured, or are they just controlled?

My own personal opinion: I think they're controlled. I wouldn't trust it. I wouldn't try it — any of them. You might go on OK for awhile, but I just tell everybody it's poison to their system. I tell everybody they know they can't try it, "You're an alcoholic. You know what it will do to you. Think of it like poison. Would you drink Lysol?"

"No. No, that will kill me."

Alcoholism — you cannot cure that. You can recover, but it's always there. I've heard people say they use cocaine for a year and stop — no more than two years. They could control it. The key to all the substance abuse is control. And most of the time you cannot control it. In some states marijuana is just a misdemeanor. But I don't trust any of those illegal drugs.

Governor Miller appointed me to be a member of the Commission on Substance Abuse Education, Prevention, Enforcement and Treatment. I was one of the original members on this board. I think it was fifty on the board, and it started in 1989. We

meet, usually once a month, in cities around the state like Elko, Reno, and et cetera. We have ideas and try to have plans to present to Governor Miller about how we can treat substance abuse in the state. I really enjoy that, and I was reappointed again this year for a second term.

I would like for them to have a program in the prisons for substance abuse inmates. They used to have AA in the prisons. It was voluntary; you go to AA if you want to. I think pretty soon it's going to be reality. It will be a structured program, like the care unit, with counselors and et cetera; inmates can go through the program. If they complete the program, they'll learn more drugs. You know, I have a young man I know who has been incarcerated about three times. He did not know anything much about substance abuse. He goes to prison, just to do his time. He comes back, and is chemical dependency-free for a while, and then goes back again. I asked if he knew anything about cocaine, what cocaine does to you. He didn't know that cocaine affects your immune system. He didn't know what alcohol can do to you. If I had a program in the prison, they could learn. And I think that that's going to be reality. Our commission has been working on that for a long time. That was one of the things we presented to the governor, and I'm very proud of that.

I'm real glad the governor got this commission together. We have people now for education on addiction; we have wonderful people on this commission. We work hard trying to iron out things so we can help our state become more involved with the drug problem. I think we've done a good job. Everyone on this committee, they're very dedicated — all of the people. And we've done a good job.

QUINCY FORTIER, M.D.

Dr. Quincy Fortier is a native of Auburn, Massachusetts, born in 1912. He attended schools in Shrewsbury, Massachusetts, and started college at Clark University in Worcester, Massachusetts. He finished his undergraduate work and two years of medical school in South Dakota. He transferred to the University of Minnesota where he received his M.D. in 1945, after he completed his internship in Wichita Falls, Texas.

His first practice was in Pioche, Nevada, as a general practitioner. After several years there, and a brief sojourn as a physician at the University of Nevada, Reno, he left Nevada and returned to the University of Minnesota for an OB/GYN residency. He served in the air force for three and a half years at Rayme Air Force Base in Puerto Rico, then returned to Nevada, establishing an OB/GYN practice in Las Vegas. He was a partner in the building of Women's Hospital in 1960, and was a pioneer in infertility procedures in Las Vegas.

Dr. Fortier still maintains a limited practice in Las Vegas.

Quincy Fortier, M.D.: I was born in Auburn, Massachusetts, that's West Auburn, I should say, September 16, 1912. I was the fifth child of seven children. My father was originally interested, very interested, in medicine. Due to the Spanish-American War coming on and his having to go to war and then being injured in the battle of San Juan Hill, he didn't go back to college. When he came out of the service, he and my mother married. He was always interested in books, and he became a book binder. He did book binding and that sort of thing for as long as I knew him. Then he and my mother were divorced, and he went west and worked for the railroad as a dispatcher until he died. I stayed with my mother after the divorce. My mother was in nurse's training when they were married in Boston; she didn't finish her training.

I went to school in Massachusetts, in the area of Worcester. I started in Shrewsbury, which is a little town. During the First World War women were going into the shops, and they wanted the children to be getting some

training while they had to leave home. Most of them could not work at home. And so they started a school, I think called kindergarten. That's a thing that they were introducing from Germany. So they started this school, and I got a chance to go to that. Of course, after the war was over, they stopped the kindergarten and never had a kindergarten any more for about ten years. [laughter]

We lived right around the Shrewsbury area. Shrewsbury is just across the lake, Lake Quinsigamond, from Worcester on the Boston side. I went to school there, and then from there I went to Boyleston to work for my board and room when I was eleven. I went to Boyleston schools until I got through grammar school. They didn't have a high school, so it meant going over to Shrewsbury. Everybody from the town of Boyleston went to the school that was nearest them, and they were boarded by different cities — Clinton on one side, West Boyleston on the other, Northborough, Shrewsbury, and Worcester. So they all went to different schools. Since I was on the Shrewsbury side, why, I went to Shrewsbury. But if I had done that from Boyleston, they would have had to pay tuition for me in Shrewsbury. So I bought a little piece of land in Shrewsbury and built a little house and lived there, went back and forth from there to Shrewsbury High School.

When I started college, I went to Clark University in Worcester, Massachusetts. Then I transferred to South Dakota because there were no state medical schools in Massachusetts. I had to get into a state, like South Dakota, that had a medical school because I was not able to pay tuition. I built a house there and took my first few years in medicine there. I finished my undergraduate college and then went into the first two years of medicine at South Dakota.

Just recently I found that when they wanted to build a medical school here in Nevada, why, they went to South Dakota to use their basic plan for school. [laughter] South Dakota hadn't gone for a four-year school yet. It was just like Dartmouth: they had the first two years, and they transferred the students at the end of two years to various other universities, and never had any trouble transferring. I was to go to Vermont, but when I got out I didn't have any money. I had been doing work at the University of Minnesota, and they gave me a position as a teaching fellow in anatomy there. I had two years in South Dakota, and then the last two years in Minnesota. Between that time I had done pathology and anatomy in the graduate school.

Anita Watson: What year did you finish medical school then?

Well, as you probably know, when you graduated then in Minnesota, you did not get an M.D.; you got a M.B. After you had finished your internship and finally gotten your license and all, and passed the examinations, then they would issue your M.D. Because of the way the law was written in Minnesota, they didn't need to go have an internship. They could go out into practice. But when they got to the point where everyone required internships, what they did was put a law through that they would not grant an M.D. until after they had their internship. Why then they could get around the law easily. And that's the same as the Canadians. So I got my M.B. in 1944 and my M.D. in 1945. I interned in Wichita Falls, Texas. So then I came to Nevada, Pioche, in general practice. That was in 1945. Dr. Ross was on the Board at that time; I don't suppose he's still there. So there

were three members at the time, Dr. Ross and the other two members that interviewed me.

When did you decide you wanted to be a doctor?

Oh, when I was very young, my father always had medical texts around and things, and my mother, of course, was very interested in medicine. When I went to work on the farm, we had three cattle, Faith, Hope, and Charity, that were offspring of one of our bulls. Faith got pregnant, but she would miscarry, and we'd find the fetus in the pasture. Hope had one and then never did get pregnant again. Charity had two pregnancies and then got pregnant again. So I got quite interested in trying to treat their sterility. I got all the literature I could get on that. That's why I first got interested in fertility and that sort of thing.

At that time I was thinking that I would either go into law, because I liked public speaking, or become a physician. But I was very much interested in cooking, and I thought maybe I would be going to chef's school. But I definitely was going to go to college. That was primarily the influence of the niece of the woman for whom I worked. She got me interested in reading and all the various political things. Her husband was very interested in that, too. She taught in New York City and came after vacations, you know, during summer school. It made me more sure that I'd go to college, [laughter] when I got through high school, if I ever got through. So my interests did wander.

When I was in high school, there was only one other person in my class that went to medical school and became a doctor. He and I were quite good friends. We had discussed medical things. He had decided he was going to medicine, and that I was going to try to go

to medicine. He went to Tufts, because they had a program at that particular time that if you practiced in the state for two years, or where they wanted you to go, Massachusetts would pay for the tuition. So he got into that program, and got through. It was not available when I graduated. When I inquired about it, they threw up their hands and said, "Oh, we don't have it any more. And that is the happiest thing in the world." They said, "We just had a terrible time trying to get these people to do what they were supposed to do." [laughter]

So you went to Pioche in 1945 and set up practice. You took over from Dr. Hastings.

Dr. Hastings, Jay H. Hastings. He was a real wonderful person. They loved him up there. When he came there, I think there were two other doctors. After they left, Dr. Hastings was alone for many years. Then the railroad hired Dr. Denman. I've forgotten what his first name was — John Denman, I think it was. He came into Caliente. So Dr. Hastings had taken care of the whole county until that time. When I came, Dr. Denman was still practicing down in Caliente. And, of course, I was the only one in Pioche. If I wanted to get away, there was a doctor up in Ely — I don't know whether he's still living. He had a very bad back deformity. He was a rather short man. If I was gone and there were any emergencies, they would call him and then send the patient up to him. But I don't think they ever had to; I never left very much. [laughter] Not for more than a few hours all the time I was there.

I hadn't been there very long when the hospital burned, not over two years. It was just about two o'clock or shortly after lunch time when it caught fire. It started in the lumber piles from an incinerator. There were some

old logs that were burning down in back of the hospital, near a barn. That blew over, and, of course, when it got in underneath, it started the whole thing, the lumber pile and everything else. It burned the whole quadrangle and also burned the hotel. And then the store and about a quarter of the town.

How large was the hospital?

When I took it over from Dr. Hastings, he had a ward which was a three-bed ward and bathroom on the lower floor. It was built into a very sharp grade so that actually the lower floor was below ground on the front only. On the road side in the back, it went way down to your left very rapidly. They had a cellar with one private room there; then there was a two-bed ward and a toilet and bathroom on that side. To the left of it was the cellar for the house where the furnace was and the automatic stoker and that sort of thing. The next floor up was the floor where you came right in from the street. He had a long room that I turned into an x-ray room. He had another room for surgery, minor surgery. He did a lot of tonsillectomies and that sort of thing. There were two more rooms and a bath upstairs for patients.

After I moved in and got to needing space, why, I took one large bedroom that was the master bedroom, which opened into that back stairway, and got a ward with three beds. That would give us about six or seven beds. There was a big living room and dining room and kitchen and a bedroom for the house. So it was a pretty good-sized building.

You said you were in general practice. What kind of medicine did you see; what kind of treatment did you do?

Everything under the sun. From brain fungus down to toe nails. [laughter] It was

relatively isolated at that time. We didn't have very much in the line of consultants down here in the specialists in Las Vegas. The only group was the Las Vegas Hospital, but they were busy with their own men. It was actually a closed practice then in the hospital. They had very fine men there.

But it was a closed place, and our nearest access was Salt Lake City. And many times you couldn't get either direction; you know, it's snow and ice and that sort of thing. So you were pretty much required to do just about everything. I'd had a good internship. I told you I had done pathology and anatomy, so I did all my own frozen sections that I needed right there during surgery in mastectomies and any questionable malignancies and that sort of thing. I brought a dermatome with me, a freezing dermatome from Minnesota. There were the usual tonsillectomies and appendectomies and all resections and just about everything, even down to pulling teeth. Dr. Massoff did come later. He used to bring his surgical patients up, and I would give his anesthetic and assist him during those. When he left town, why, it left me to do emergency extractions and things like that when necessary. Of course, I had worked with him. He went to Reno, you know, and for many years was head of the Dental Society there. He was a very fine surgeon, dental surgeon. And it was his sister-in-law that I married.

Did you have a fairly large rural population in your practice in Pioche? Did you have to travel quite a bit?

It was a large area. I started out by operating down in Caliente. I did tonsillectomies; it was just a continuation of what Dr. Hastings did, you know. But I did all the general surgery down in Caliente at the hospital there. Then

Dr. Denman left that area and went down to Las Vegas. He was the railroad doctor there, and after he left the hospital sort of went downhill. One evening, early one evening, on a very, very stormy night they called me. The man who worked in one of the stores right in back of me was in terrible pain. I knew he had a hernia, and he was wearing a truss, and he had strangulated. The weather was so bad there was no way of getting out of Pioche at that time. My nurse gave the anesthetic under my directions, sodium pentothal. That was the first operation, major operation, I did up in Pioche, to reduce the strangulated hernia. There was no time to get to Salt Lake City. I didn't go down to Caliente because I called down there, and the girl who answered said, "Oh, God, don't bring anybody down here. All the nurses and all the town drunks are having a party over there." She didn't actually say they were drunk, but she said, "There's no way that you could do any surgery down here tonight." [laughter] And so I had to go ahead and do it.

Did you do OB/GYN also?

Yes, yes, I did deliveries. That was a big part of the practice. The practice extended actually from southern Utah, because after I built my big hospital, why, we had an awful lot of referrals from southern Utah. People would bring us students and a child that was ill or had to have surgery or something. They would bring them over, and they'd leave them, a child or a young person or whoever it's going to be, and tell you to call them when they were ready to go home. [laughter] But we'd have feeding problems and that sort of thing that they'd bring; we'd have them as house guests as well as patients during that period. That was before we built the big hospital. When we built the big hospital, it still continued even more so.

And you did house calls?

Oh, yes, that was the thing. That was one of the main reasons I had to have a place in Pioche, because I had to go out to Eagle Valley and even as far as Alamo. But I didn't like to do much at Alamo. The distance, the driving over there. They would want you to deliver over there, you know, home deliveries. I couldn't do that; it's just too far to go.

How long did it take you to get from Pioche to Alamo?

Well, I think it's nearly a hundred miles over there. My car I was driving was a big Oldsmobile, and I always traded it every year. And they had these big Chryslers, the Chrysler New Yorker, and they could go one hundred, one hundred and five miles an hour. And that's the way if I ever went to Reno, I would go over in the morning and come back at night, you know. But I didn't do it a great deal. Most of my patients from Alamo came over to Pioche and then also from Panaca and from Caliente. And, of course, Dr. Hastings was with the railroad and was there so that he was able to take of most of those people down there. Mine was primarily the area from around Eagle Valley. There were two settlements that they call Eagle Valley. They changed the name to Ursine, and kept the name on Eagle Valley for the one over in Carson. Well, anyway, there was Ursine and then to the north toward Ely. Some of those people lived out about a hundred miles. Of course, Ely was a hundred, a hundred and ten or twenty-five miles. Ely had their two facilities up there, but they belonged to the mines. You know, they were mine hospitals. It was one of their doctors that was up there that agreed to take my patients if there were any emergencies. But, of course, they would

not come down; the patient would have to go up there.

I had to use my ambulance to transport them if they needed to. Most of the people that were from mines I ambulated until I got my facility up there in Pioche. I would take them in the ambulance. Actually Dr. Hastings's ambulance was a converted sedan, Chevrolet sedan, that he had to fix so that you could roll them in from the compartment, from the back. The head would be up toward the back seat of the driver, and it worked very well except when you had people who were really heavy. Why, then you had to be careful; they had to hold their breath as you pushed them through underneath the cowl. But I converted a van into an ambulance that I used for carting or transferring if I had to any great distance. But most of them were transferred until I got my facility. I even had to transfer the military people sometimes.

How long did you practice in Pioche?

Well, I was there until 1950, when I took a job at the university and sold the hospital to three men. One was a military naval officer, and two younger men who were out of their internships. It was too much for them, and they squabbled because they all had too much work to do. They would be on call for twenty-four hours, and they did only about half of what I did as far as practice. [laughter]

Then I made arrangements to take my residency, which I had planned for a long time. I had done my internship in Wichita Falls, Texas, and at the University of Minnesota. When I went back, the head of OB/GYN said, "We can take you back; we are very anxious to have you back in the residency program, but we don't have any positions open." But they could admit me into the residency program and pay me as an

intern. That was twenty-five dollars a month and a room in the intern's quarters. [laughter] Of course, I had a family by that time, and we had a house. The program covered me for life hospitalization for my family. The residents didn't get this, but the interns had free medical care for their families and themselves. So that came in good stead because I had to have an operation during that time. [laughter] And my wife had three children during that period of time. That coverage extends even to the rest of my life because I can go back for medical care at the University of Minnesota without paying anything in addition to the programs that we have.

What year was it that you went back to Minnesota?

Nineteen fifty-one. And I completed in 1954. The year before my residency was completed, they had notified me that I had been assigned to the army. I wrote them back a letter saying that I would be glad to come, "The only thing is I'm right at the end of my residency, and anyway you didn't send the papers that I needed to carry out my assignment" — you know, take care of all the papers. "In time, why, if you want to, I'll be here and available, you know, if you will just contact me again."

So they never did contact me until one afternoon when they sent me a notice from the air force. They called me in, said I'd been assigned to England, and to start filling out the papers. They needed somebody very badly there, and the man who was the head of the base was anxious. So I talked with him on the phone and also got letters from him. He said, "I'm leaving the base house, so there'll be a home for you. I've made up my mind that my OB/GYN physician is going to be on base. They have had too much trouble off

base, and there is no other base housing but my place.” He said, “I will give it up and you can have that.” I had six children by then and one on the way.

Then all of a sudden they wanted to keep me on at the university; I could stay on as a teaching fellow and OB/GYN. So I was staying there until I got an urgent call from the air force. They said, “We need you down at Rayme, the Air Force Base in Puerto Rico.” I didn’t even know where Puerto Rico was. [laughter]

So I said, “What’s the catch?”

“That you go at once.”

And I said, “What do you mean?”

“Well,” they said, “on Monday.” And that was on Thursday or Friday.

I said, “Well, I’ve never been in the service, and I don’t have any of the papers or anything like that.”

So they said, “We’re going to get concurrent travel for you. If you can’t get concurrent travel, we won’t send you down.” That’s for your family and all that sort of thing.

Well, anyway I contacted them down at Rayme, and they called me on Monday and said, “We’ve got concurrent travel for you. We’ll give you five more days to get down here and get all your paperwork in. You can get it at the base out there at Fort Snelling.” So I started out trying to get the paperwork. First of all, you know, I was going on the basis of a telegram. That’s all I had on that. [laughter] But they finally started pushing me around through to the various things and all the papers that are necessary to get into the military. Anyway, I got my orders and had to make up for my family and close the house up. The following Monday I was on duty down at Rayme. The air force even managed to get a uniform.

How long did you stay in Puerto Rico?

I was only supposed to stay there two years. Of course, that was all that was necessary. In the meantime they had changed the age requirement; if it had been six months later they couldn’t have taken me anyway. But, anyway, when I got down there, it was so terribly busy and all, and they couldn’t get anybody to replace me at that particular time. I extended then because my children were in school; the last one wasn’t out yet. Then the next time when they were supposed to replace me, why, the replacement was real late, and they asked me to extend again. So I extended again for another half year. I was there for three and a half years, and I was supposed to only stay two years. And then I came back up to Las Vegas.

Did you go into private practice then in Las Vegas?

Yes, yes. I immediately looked for a place to buy, and I bought the old Mesquite Club down here, a women’s club, and changed that into an office. It was on Fifth Street right near the courthouse. It’s a wedding chapel now. And I practiced there, it was 1959, with Dr. O’Donnell.

Then he said, “You know I always had dreams of building a hospital.”

I said, “I’ve been all through it; I know what it’s all about.” I had a piece of land that I bought for it, but I couldn’t get zoning — it was on West Charleston.

They said, “Nothing is going to be commercial beyond the railroad tracks, especially nothing beyond the hospital or the Southern Nevada Memorial.” They couldn’t have ambulances rushing up and down Charleston Street.

So Dr. O’Donnell said, “You know, I’ve looked into this situation. I know of a piece down here on East Charleston, and I know we

won't have any trouble there getting zoning." He had his office down close by there, and had gone through the mill. So we decided to build Women's Hospital over where it is now. We completed it and opened it in 1960, but we were doing the ground work and all the other things in the building in 1959.

How large was it?

It was thirty beds, I believe, and ten or twelve bassinets. We operated on more than that; we were frequently filled up and using the corridors and using the doctors' change room for post surgicals. I drew up the plans for the new addition that was built right after we sold it. They followed pretty much the original plans; I don't know how many beds they are operating on now. But I just heard the other day that Sunrise had bought the hospital.

So when you had the hospital, were you working as both the hospital administrator and a physician?

The first administrator that we had was killed, but he was there for a whole year, year and a half, but we had a very excellent financial director. Of course, Dr. O'Donnell and I took care of all the administrative things; we worked together and took care of all the finances and everything else. That was no problem because from the day we opened we were in the black, and then we ran through the black.

Why did you build the hospital?

Southern Nevada had a very poor facility, and that was the only other one. They had those wards down there that were so bad that when they turned on their cooling system, they would

practically blow you out of the general ward. [laughter] Or else they had to turn them off and burn up. They knew it, but they were in that old building — well, it was the very first building that was built there, and there was no prospect of getting any enlargement done. And at that particular time, when I came back, they were just beginning a building on Sunrise that would eventually be Sunrise Hospital. They did not want to have much to do with OB/GYN because it just didn't pay anything. Dr. O'Donnell used to take some of his patients out to Rose De Lima, but that wasn't very satisfactory either. There was such a great need for an obstetrical service that it was the wise thing to do.

You've seen a lot of changes.

Yes, many changes. It was interesting — when I came for my boards, to be examined, Dr. Ross introduced me to the two other doctors. He said, "We've been going over your records, and we understand that you that you are planning on going to Pioche." He said, "You know, we'd like to keep Dr. Hastings over there for another year or two. We would certainly like to have you go some other place." They had some other places in mind.

I said, "Well, I talked to Hastings, and he had made up his mind by the time he was fifty-nine he was going to retire. And he's going to be sixty-two. His mother and father aren't too well, and he definitely wants to retire." They were ninety-four and another one was close to one hundred. They lived over at Sioux City, Iowa. And he was going to go over there. So they didn't pursue that any longer.

Dr. Ross and the other doctor were to ask the questions in anatomy and physiology. He said, "Dr. Fortier was an instructor at the University of Minnesota, in the Anatomy Department. Do you want to ask him some questions?"

The other doctor said, “No, we can skip that,” and looked over the records. So that was the way he introduced me to the others. Dr. Ross was a very gracious person; a great addition to the Board. He was head of the Board for a long time. I think you’ll see his name on the records. People over there like him very, very much, I know. The other doctors sitting on the Board, for that matter, were very good people.

Did you have any other contacts with the Board?

Never did I ever. It was rather interesting. I would meet some of them once in a while at medical meetings. Of course, I’ve known Dr. Jacobs, and he knows me. Dr. Cammack was on the Board. He was at Southern Memorial when I was over there. But I never really did have any official connection with them. In fact, it is always hard to get to the State Medical Association meetings.

Were you a member of the State Medical Association?

Oh, yes, yes. That was right from the very beginning. It was there I delivered a little report on progressive synergistic gangrene patients that we had that died.

I never did stop my membership. I kept my membership even in the military. I’ve kept on. And, no, they don’t bill me any more. AMA stopped billing at a certain age; I think it’s seventy-five or something like that. And then the local society only stopped, I don’t know, a year or two ago. But they still keep you on as a member, but they stopped the billing when I hit eighty, I guess. [laughter] I’ll be eighty-two this year.

When you came to Las Vegas and were practicing with the OB/GYN, did you continue

with house calls? Or had medicine changed enough by then that . . . ?

I could usually get out of them. That was one of the hardest things to do. If you’ve done family practice and general practice and things like that, why, it’s very difficult to turn people away. But I gradually over a period of time referred them to other people that would take care of them. Special people I would see and tell them, “It would be better for you to see so-and-so.” Gradually got it changed, so I could get away from that.

Of course, my major thing was infertility. I told you how I got interested in it, and I always retained that interest. I was the only one that was really doing infertility. Or who would be interested in bothering with it. I was doing tubal reconstruction work and all that sort of thing. I introduced colposcopy, which is peritoneoscopy, going in through the vagina between the rectum and the uterus. I started that, so they wanted me to start up the out-patient sterility clinic there, so I was the first one.

One Saturday I had a patient who needed a peritoneoscopy, and I was doing through it the vaginal approach. I said, “Look, Dr. McKelvey, would you like to see how excellent a view this is and see this particular bleeding tubal pregnancy?”

And he rather cautiously came over to look into the scope and said, “My God, can you see all that through there?” I sort of showed him a whole new view.

I stayed on in the reserve and was commander of the 468 Medical Service at Fort Nellis for eleven years. We would do the female surgery when they needed us — tubal repairs and things of that sort. I was a consultant, so that if they got into trouble, I would have to go out there night and day. Between here and Nellis was less than fifteen minutes.

Did you do extensive infertility work at Women's Hospital?

Oh, yes. About 50 percent of my practice was infertility. The only male operation I did was microscopic microsurgery, reconstruction after they've had vasectomies. I had done vasectomy repairs since 1951. Actually I started in and did those at the University of Minnesota.

Did you do in vitro fertilization here?

I did not do it myself, no. I did the concentration methods, concentrates for individuals who had very, very low sperm counts and so on. And, of course, artificial insemination. At the University of Minnesota we collected our own specimens. I remember the doctors, the residents, and the interns were a primary source for the donors that we used. But I was one of the first who brought an interest in infertility here.

What about working with women physicians? Did you see more and more women come into this field?

Oh, yes, yes. There were more coming in. We had one resident. I think was the — I'm not sure if she was the first female resident in OB/GYN. She was killed in an auto accident, and she didn't finish her residency. She went over to see her husband. She was driving back with some nurses from Christmas vacation, and they turned over in the desert. I think all of them were killed. But then we got another, a very wonderful girl from India. She had had her residency over there, OB/GYN residency, but she felt that it lacked a great deal, especially in malignant care. She took the whole three years. After that I guess they

opened up to women without any problem. There weren't too many in the field.

When did you leave a full load of active practice?

When I had heart surgery about ten years ago, I cut down quite a little. Then I had by-passes, and I cut back further when I had to have discs removed. So it has just been gradually cutting down, cutting down. It becomes such a problem even to do the billing, that the billing is a year behind. But mainly, all I do now is help people out who are in trouble.

RICHARD GRUNDY, M.D.

Dr. Richard Grundy was born in Oklahoma City, in 1928. He attended public school there through the tenth grade and finished his high school education at Howe Military School in Howe, Indiana, graduating in 1947. Dr. Grundy attended the University of Chicago for a year, then transferred to the University of Oklahoma in Norman, and received a B.S. in Chemistry in 1951 and an M.S. in Biochemistry in 1952.

After working for the Eli Lilly, Co. for several years, Dr. Grundy returned to school and received an M.D. from Baylor University College of Medicine in 1958. He served a one-year internship at John Peter Smith Hospital in Fort Worth, Texas.

Familiar with Nevada after his stint with Lilly, Dr. Grundy moved to Carson City in 1959 and entered private practice with Dr. Richard Petty and Dr. Ontie Hovenden. A family practitioner until 1975, Dr. Grundy left private practice in 1975 and worked as an emergency room physician for the next decade, retiring in 1984. He has stayed active as a medical advisor for the State Industrial Insurance System

and the Nevada State Employees Retirement System.

Dr. Grundy's involvement in medical politics has included three terms as chief of staff at Carson-Tahoe Hospital, and membership in the Nevada State Medical Association. He was a founding member of the Carson-Douglas Medical Society. He served on the Nevada State Board of Medical Examiners from 1969 to 1981. He was named "Distinguished Nevada Physician of the Year" by the Nevada State Medical Society in 1994.

Richard Grundy, M.D.: I was born and raised in Oklahoma, mainly Oklahoma City. I went to public schools there up until the tenth grade. I am the youngest in the family. I have an older brother who's six years older than I am, and an older sister who is three years older than I am. My mother is deceased now; my father, too, for that matter.

My father was a druggist, and owned several drug stores. He had an accidental death when I was about five years old, and my mother raised the three of us. She had

a college degree and a teacher's certificate, and she taught in the public school system in various towns in Oklahoma, mainly in Oklahoma City. She remained in the school system until she retired, and she was able to support us.

I guess you might say we grew up in a single parent family long before that name was coined. It really was quite unusual at that time. I remember as a kid feeling a little bit dumb and different and really not understanding why, because everybody else had a dad and I didn't. I was too young to think through those things. Now, of course, it's pretty common.

Anita Watson: You were born in 1928. Your father died during the Depression. Do you remember that and how it affected the family?

Well, as far as my own personal memory is concerned, I don't remember it; I hardly remember my father. I'll tell you a funny little story that shows how close I came to being born with a golden spoon in my mouth. In about 1931, my father owned a section of land southeast of Oklahoma City; that's a square mile of land, and it was just old range land, you know. It hadn't been improved or anything.

He owed five thousand dollars on it, which in 1931 was a considerable amount of money. He had an opportunity to exchange it for a hundred-acre farm in western Oklahoma that was a real farm. It grew crops and had buildings and things on it. The trade would get him out from under the loan that he had on this section of land. So he did it. About three years later the North Fork of the Cimarron River changed its course, and to this day my brother and sister and I own a hundred acres of river bottom out near Sayre, Oklahoma. Five years after my father made this transaction they discovered the Wilcox

Pool southeast of Oklahoma City, and the section that my father had owned happened to be pretty much in the middle of it. That's how close I came to being born with a golden spoon in my mouth.

How about your schooling? Was it emphasized because your mother was a teacher?

No, I don't think so. I went to public schools in Oklahoma City up to until the tenth grade. I enjoyed school. I was sort of a loner, and I just did what I was told as a kid. I was told to go to school and study and learn what I was supposed to learn, and so I did. As I grew up, I really can't remember giving much thought as to what I wanted to do with my life.

My first two years of high school, in ninth and tenth grades, I was starting to run with — shady characters, shall we say. I was beginning to think it was more fun to drive around in cars than go to school. I think my mother, in her wisdom, realized that I really had no male figure in my life. She was teaching and trying to keep my brother and sister in college and still trying to raise me. She realized it was more than she could do. So off I went to military school, Howe Military School in Howe, Indiana.

I have always sort of been interested in music, and I was able to get a scholarship to this military school mainly because of my music. They had a little band, and my job was to go there and play whatever instrument they didn't have that year. That put me in a more masculine environment and I think did me a lot of good. It taught me that you've got to be responsible for yourself. Helped me grow up, we'll say.

Was it tough?

Oh, no. It was very strict and very organized, but then I was a follower. All I did

was what I was told. I guess in military school, like the army, if you do what you're told, you never get in the way of trouble. [laughter] So that's what I did.

After high school, I went to the University of Chicago for one year. This was when Charles Hutchings was running wild there, and I took his four philosophy courses. I never studied, and I had the dubious distinction of attending the University of Chicago and flunking out. I went home to Oklahoma City that summer, and I got a job. I sat down and had several long talks with myself and got into the University of Oklahoma that fall. From then on I paid attention to my school work and did all right.

I was a member of a fraternity down there. To show you how immature I was, I was told that being a member of this fraternity, Lambda Chi Alpha, was wonderful. All through life it would help you so much — slip a fellow Lambda Chi the secret handshake and all that, and it would just open doors.

In the fraternity there was a rowdy bunch, and then there were those who were students. I sort of got in with the students and let the rowdy ones just be rowdy, you might say. The interesting part of it is after I graduated and got my first degree, to this day if I have ever met another Lambda Chi Alpha, I'm unaware of if. [laughter] Nobody ever slipped me the secret handshake, and I guess of all the people I've met in my life, we had other more important things to talk about than what fraternity we were in when we were in college. [laughter] It did give me a place to live.

I didn't get my first degree for five years because I kept changing majors. Would you believe that I was a business major? I majored in physics, and I was even a music major for one semester. Finally I got my first degree in chemistry; it took me five years — I do not regret that now. In fact, I am really quite happy

about it because it gave me a very broadened undergraduate education, where medicine is very concentrated, a very narrowing type of education.

I went on and got my master's degree in biochemistry at the University of Oklahoma, the School of Medicine, which was in Oklahoma City. I really would have liked to have started medical school then, but we just didn't have the funds. So I went out into the big wide world to earn a living and went to work for the Eli Lilly Company for about two and a half or three years.

That was, of course, in the early 1950s. If you will remember the stock market in the early 1950s, all it did was go up. I was on a full expense account. I traveled all over the country for Lilly, and I would take my paycheck every month and just invest it in the stock market. At the end of about two and a half years or three years I felt that I had enough money that I could quit and go back to medical school.

Were you still single?

I was still single, although I had met my future wife at that time. She's pharmacist. I sold her a bunch of pills in Ohio. In fact, I guess you might say ours is a typical story of the farmer's daughter and the traveling salesman: I was a traveling salesman, and she was a farmer's daughter. [laughter] That's almost forty years ago, so it lasted pretty well. [laughter]

I was admitted to Baylor Medical School in Houston after I decided to go back to medical school. Dr. Hovenden here in town was the one that really convinced me I should do it. I was vacillating back and forth. He told me one time that you only live once, and if you don't do what you want to do that one time you live, you don't get a second shot.

That impressed me so much I went home that night and wrote a bunch of letters asking for admission to medical school. I started that fall.

Nancy and I had sort of kept up our relationship by long distances. We got married during my freshman and sophomore year in medical school. My wife put me through school mainly, and we were able to save that money that I had. I certainly appreciate her effort on my behalf, I'll tell you!

Going through medical school wasn't like going to college. I think it's fair to say that in medical school I really got down and worked and studied for the first time in my life. I don't look back at that as all this drudgery and hard work and study. I was studying anatomy and physiology and pharmacology and biochemistry and all these scientific things. To me it was like spending the weekend reading a novel — it was so fascinating and interesting. Although I am sure I put in as many hours as the rest of the guys, I never looked at it as a lot of hard work. A lot of hard fun, maybe — put it that way. I was just real fascinated by that kind of thing and still am. Then you get to the last two years where you are able to start seeing real people, under the closest of supervision, of course. That really turns you on!

Let me tell you about one of the first patients I ever saw. Now here I am: I'm a third-year medical student, and I don't know you know what from shinola. My first rotation was in the ear, nose and throat clinic. One of my first patients was an elderly colored gentleman, I'd say somewhere in his seventies. I remember him just like it was yesterday. He was sitting in this steel ENT chair, tears streaming down his face, and he said, "Doctor, I can't hear."

I picked up the little otoscope, that's a thing that doctors look in your ears with, and

I looked, and there was probably a fifty-year accumulation of cotton, match heads, wax — I don't know what all — just packed in there. I showed it to the resident, and he said, "Wash it all out." Which I did. It took me about an hour, I guess. I walked around in front of him, and I said, "Can you hear now?" [laughter]

His eyes got great big, and he stood up from the chair, and he said, "Lordy, the doctors have performed a miracle." The last I saw of him he was going out of the room shouting, "The doctors performed a miracle!" I just sat there with my mouth wide open. [laughter] I'll tell you that turns you on: if you can help somebody like that, it's worth living for. [laughter]

I had the opportunity of doing that thousands of times after that. Maybe without such a glorious vocal response, but still with the inner satisfaction of being able to help somebody who is deaf. That's what I mean when I say, "That's what I got out of medicine" — that was the fun of it.

What about the downside to it?

Well, I don't know. I guess any job you take there's an upside and a downside. There are a lot of sad things that you're in the middle of — people dying and the feeling of hopelessness and helplessness. I learned very early I would never go to a funeral of one of my patients. To me it was like walking in there and admitting defeat. I just couldn't handle it, so I didn't go. But I don't know, but that's just part of the game. You just do that, too. There's always a new day tomorrow; you start over.

Did you find yourself at times second-guessing decisions?

Well, you always do that. You see somebody, and you arrive at a diagnosis.

Then you formulate in your mind a plan of treatment. Every time you see them you say, “Well, are things going like I’d expected them to go? If not, why not?”

If something goes wrong you say, “Well, what went wrong? Why did it go wrong?” Then you do what you can to right the wrong. I’m not so sure that’s different from a lot of other things. Maybe it’s got a little bit more resting on it, you might say. [laughter] But you just don’t diagnose somebody and say, “Here, take these pills, and don’t bother me any more.” Because I don’t care what you do, nothing you do is 100 percent right for everybody. You’d better watch them as you go along to be sure that they’re doing what you expect. So that kind of second-guessing, yeah, I second-guess myself every day, all the time. Because if they didn’t do like I would have expected them to, I’ve got to find out why.

What about your internship?

It was just a regular internship in Fort Worth, Texas, at a place called John Peter Smith Hospital, a city-county hospital. I went through every service there. Back then we were short of interns and residents, and so was everybody else. That was during the time of the big doctor shortage, and so we all worked, I would say, an average of twenty out of every twenty-four hours.

We learned a lot, and, of course, I was thrilled with being able to do things. I don’t begrudge that at all. It was fun; it was neat. A lot of hard work, but I really didn’t mind that. If on a Saturday night you gave me the choice of going to a movie or going down to the hospital and delivering a baby, I’d take the baby any day of the week. I don’t care how good the movie is; that’s just — that’s my fun. It was that way then, and I would say remained that way pretty much until I finally quit.

When you went into your internship, did you know what your specialty was going to be? Did you have a preference?

Well, I remember, I really ticked off the medical school, the head of the Department of Pediatrics. In the first part of our senior year we were all supposed to see our advisors. Baylor was trying to make a name for themselves — which they did and which they justly deserved. One of the ways a medical school makes a name for itself is to send their graduates into tough residency programs and have them do well. Then they say, “Oh, he came from such and such. Yes, it must be a pretty good school, you know.”

I was in talking to my advisor; he was a grumpy old guy, but he was friendly that day. He asked me what specialty I was going into. I said, “Well, I think I’m going to be a general practitioner.” He laughed and he laughed and he laughed until he looked at me and decided that I was serious. He just couldn’t believe it. He spent about the next hour trying to talk me into going into some specialty. I spent about the next hour telling him I didn’t want to do so, and I really ticked him off.

But by then I had decided that I was so interested in every field of medicine that I wasn’t going to pick one — not because I didn’t like it, but because I wasn’t willing to give up all the rest. That’s why I came out as an old general practitioner. That was before the musical words of family practitioner came along. I was just known as a G.P. That, of course, is what Hovie was and what Dick Petty was, and I admired those two men greatly. I thought, “Boy, if I could be like them, that’s good enough for me.” That’s why I’m an old G.P. [laughter]

Do you think it’s possible for someone to do that now?

No. The whole world has changed and medicine has, too. The closest thing that one could probably do now to what I did would be to specialize in family practice, which would mean another two years of training. Or to become an internist; they are primary physicians. Or if you can put up with mothers and fathers, be a pediatrician. Kids are fun to take care of; it's the parents that drive you up the wall.

You have to remember, when I practiced in Carson City, up until the time I closed my practice, which was 1975, I did most of my own surgery; I delivered my own babies; I set bones; I took care of heart attacks; I did a little bit of everything. I don't think there is any chance of a doctor doing that today in this country.

Practicing in a small town you almost have to be multi-oriented?

Yes, that was true back then, but it's not true now. Let's say I wanted to go out and practice in Austin, Nevada, today. The reason I couldn't practice in Austin, Nevada, today the way I practiced in Carson City thirty years ago is twofold. Number one, Austin obviously does not have the ancillary medical facilities that Carson City had then. They don't have anything that even resembles a hospital. You can't do it by yourself; you've got to have laboratory people, x-ray people, and all that stuff.

The second reason now is the malpractice situation. I wouldn't dare take care of somebody with a heart attack today. Whether I was competent to do it or not doesn't matter — I couldn't afford it if something went wrong. That's the problem. Everybody's too litigation minded. People in Austin, Nevada, aren't that dumb either. If I take care of some rancher up there who had a heart attack and he died,

they're going to sue me. Even though they say, "Well, we can't go to Reno." They're still going to sue me. Why? They know where the money is; that's why. "Boy, pay off the ranch!"

So what's the solution for people in Austin, Nevada?

Well, how long is this interview going to go on? [laughter] I'm not going to get into that — my day is past. Let me say this: the solution to the problem, unfortunately, will not come from the Nevada medical profession; it's going to come from the politicians. And I don't care what they start off with; it's going to be somewhere between bad and terrible. I can only hope that the next generation, after they start with whatever they start with, will have enough honesty and wisdom to change it to try to improve it.

I don't think medicine will ever, ever be practiced like I practiced. Just like I would never think of cutting off somebody's leg above the knee with a sharp scalpel and a hacksaw and sticking the stump in boiling oil like they did in the Civil War. Progress goes on, and I would have to put the "progress" in quotation marks. Not all of it is bad, and not all of it is good either. No.

I'm pretty down on it. Let's put it this way, none of my kids went into any field of medicine, and I'm happy. I knew what it's like when it was fun. And it's no longer fun. You see doctors working hard and making the big bucks. I don't blame them. It's not fun any more; you might just as well get something out of it.

When you finished your internship, you did not have to have any sort of residency to qualify as a G.P.?

No, no. At that time in order to get a license to practice medicine in the state of

Nevada — well, I guess about any state in the Union — you had to graduate from what they called the Class A schools, and you had to complete one year of a rotating internship. That was all the legal requirements that they had at the time I got my first license in Texas, and it was reciprocated out in Nevada. Now I think there's more. And there probably should be, too.

Did you practice in Texas at all?

No. It's customary to get your original license in the state where you went to school because in order to get that original license, you had to take an examination as given by that state board of medical examiners. Then you could reciprocate into other states.

My wife, Nancy, had given birth to our first child just two weeks after the end of my internship, so she went to spend time with my mother in Oklahoma City. I came out to Nevada, driving one car and pulling another. Nancy and the baby flew out a few weeks later after I had found a little place to live.

Working for Lilly, I got to know Dr. Hovenden pretty well, and Dr. Petty, too, for that matter. When I went back to medical school, my dream had been to come back out to Carson City or come out to Nevada. I really liked it out here.

What was special about it, compared to the other areas?

Well, I never did like rain. [laughter] Especially after four years in Houston, I really didn't like rain. I liked the dryness; I liked the high altitude; I liked the weather, the sunny weather, yet with four distinct seasons. I liked the small town, the rural type of life. Even though most of my growing up was in Oklahoma City, I preferred the small town, and it just all seemed to be here.

I'd kept up a little correspondence between Petty, Hovie, and myself all during this period of time because in the back of my mind I thought it would sure be nice to go to Carson City and associate with such fine guys, you know. I was lucky; that's just the way it turned out.

I got to Nevada, in August of 1959. The Nevada State Board of Medical Examiners had their next scheduled meeting in September. I rented a little house here and just sort of bummed around. I couldn't practice, obviously, because that's a big "no-no" — to go into a state where you don't have a license and even ask somebody to open their mouth. I was very careful; I didn't do anything until I met with the state Board.

I was supposed to be there at the Riverside Hotel in Reno at ten o'clock in the morning. I sat outside the door all day long. As far as I know, I was the only person who was coming in to get a license at that time; if there was somebody else, I never saw them. About six or seven o'clock that night they called me in, and they asked me some very simple questions — how you treat a snake bite, a pit viper bite or something. I told them, and they just sort of all congratulated me, "OK, you passed."

Of course, they had all my records and things there to go over. I don't think there's any question that Dr. Petty and Dr. Hovenden most likely put in a word or two concerning me, and that never hurts, you know. They weren't exactly dealing with a totally unknown entity. I asked George Ross, "Well, when can I start practice?"

He sort of looked up at me and smiled and said, "I'd wait until you got back to Carson City." [laughter] And I started work the next morning. Two or three weeks later I got my license. Everything was sort of done in an easy-going manner then. But I would argue with somebody if they said it was lax or not

thorough enough. Maybe they didn't write everything down, but they knew what they were doing. Of course, today the idea is write everything down. Whether you know what you are doing or not really doesn't make a whole lot of difference, as long as you have it all well documented.

The next day I moved in with Dr. Hovenden. For about the first two or three months I would sit in his office while he saw patients. Nobody came to see me, you know. Dr. Hovenden would introduce me to them, and, of course, they would chat and were very polite, and then they would say, "Now, Dr. Hovenden . . ." and they would start talking about their medical problems.

Well, you can understand that. But a few of them rubbed off, especially when I started taking Dr. Hovenden's night calls. In doing that, why, once the people got over the idea that no, they weren't going to see Dr. Hovenden at 2:00 a.m., then I would go ahead and take care of them, and they seemed reasonably happy. So that's how my practice started.

Gosh, if you could have talked to Hovie, he would have really given you the story. I remember his telling me about his service in World War I. Him standing around in wards of thirty, forty, fifty men who had influenza and watching them die. Once he got out of the service he came to McGill, where he worked most of his practice life for Kennecott as a company doctor. At that time one of the perks, you might say, of working for Kennecott was free medical care, and he was one of the doctors that provided that care. After he retired from Kennecott, he moved to Carson City, and he started to practice here. He was here for seven or eight years before I came to town.

Dr. Petty was very helpful. Dr. Petty, I think it's fair to say, had the biggest OB

practice in town at that time. I remember that the going obstetrical fee at that time was \$100. If it happened to be a boy, why, you threw in the circumcision for nothing.

Dr. Petty dearly loved to hunt ducks. Every Wednesday from Tuesday evening until Thursday morning he was gone. And every weekend from Friday afternoon until Monday morning he was gone; usually down to Stillwater or someplace hunting ducks. That was during duck season, of course. During that period of time I covered for his OBs, and he gave me fifty bucks for every one I delivered. That's what kept Nancy and I and little Susan alive and well fed that first winter, delivering Dr. Petty's babies. Of course, they get to know you, and then they would start to come and see you as a physician.

Dr. Petty didn't care; neither did Hovie. At that time everybody in town had more patients than they could really take care of. If they found out that one of their patients was seeing somebody else, it was an occasion for rejoicement, not worrying about what happened. We were just all so busy. The doctors in town got along so well that if one of my patients started to see Henry Stewart, why, Henry would just walk up in the hall in the hospital and say, "Hey, Mrs. So-and-so is coming to see me. Tell me about her kid's diabetes."

I'd tell him, "I'll send the records down." We all worked together and cooperated together that way. That's one of the things that made it fun. I can remember we had these sort of unofficial consultations on patients in the hospital. If a guy had a tough case, why, he'd come out, and we'd sit and talk about it — him, I, and maybe one or two other doctors — we'd sit and talk about it for twenty or thirty minutes and try and help him with it. If it was me, they'd try to help me with it.

As I look at it now, you know, who really profited by it? The patient. They were the ones that profited by it, to have four heads instead of one working on him. That's how we practiced then. A guy would call me up and say, "Geez, I need somebody to help me in surgery." I don't care if was day or night, you went because you knew the next day you may have to call him and say, "Oh, geez, I need somebody, too." If we all hadn't worked together that way, I don't think any of us would still be alive.

I don't know if you are aware of it or not, but this is unique in medicine. Are you familiar with Reno? I don't need to tell you how many factions there are in Reno and Las Vegas. We didn't have factions here in Carson City. Oh, every now and then, one of us would get mad at another guy, but we got over it; we always worked together.

Why do you think?

Why do I think that happened? I think it was because we were all so busy that we realized that by helping each other we could get through the day in better shape and give better care to our patients. If somebody comes in with some oddball symptoms, I don't have to spend forty-five minutes looking it up in the book; I'd go down the hall and ask Dick Petty. You see what I mean? Save myself a lot of time. That's where it helped. And anyhow, so it's a fun way of doing things.

What medical facilities did you have?

Carson-Tahoe Hospital was here in 1953 when I was a drug salesman out here. The hospital had about sixteen beds, one surgery, one delivery room, a small, one-machine X-ray department, a smaller lab, and a drug room that was literally in a closet. The

building was a wooden framed, brick veneer structure with a shingle roof.

By 1965, it was obvious to all the doctors and most of the citizens that the old hospital had gone from inadequate to wholly inadequate. It was owned by a non-profit corporation, and non-profit it was. By 1965, it was pretty deep in debt. Politics were a little simpler back in those days, and with a bit of campaigning, the doctors were able to convince the county to buy the hospital (for \$1.00). Then, with a bond issue, significant community contributions, and Hill-Burton funds, the contract was let to build a new hospital on the site of the old hospital.

About halfway through construction, the county commissioners got the idea that the old hospital would be a wonderful place to put some city/county offices, like the building and sewer department. This was a problem. It was brought out that the Waters family had donated the land for the original hospital with the condition that if it were ever to be used for anything except a hospital, the land would revert to them.

This grew to quite a controversy in town. I remember many patients asking me how I felt about the problem, and I told them, "When the new hospital is completed, I'm going to burn down the old one."

The old one did burn, didn't it?

The old one burned when the new one was about three months away from being finished. Fortunately, I was not charged with arson. The contractor at the new hospital was burning trash, and a big wad of burning excelsior had come out and landed on the roof. The fire department came out, and it became obvious to me that they did not know whether they could stop it or not. We started evacuating patients.

At that time Stewart Indian School was still open, and we either sent the patients home, or we sent them out to Stewart Indian School, which had a little school hospital. Miss Hersey was the nurse out there and was very helpful indeed. She had worked out there for years, wonderful person. I think a couple of the serious ones were transferred into Reno. The hospital burned literally to the ground, as you know, without a single patient being injured. The worst injury was a fireman who stepped on a nail, and we gave him a tetanus shot. So that went pretty well. [laughter]

At this time you were called Carson Medical Group, across the street from the hospital on Mountain Street. Is that where you started your practice? Was that your first office?

Well, no. My first office was with Dr. Hovenden, whose office was on Curry Street; I believe it's Curry and Musser right catercorner from the old fire station, next door to the house on the corner where Mrs. Kitzmeyer lived, whose husband was the Kitzmeyer Drug Store.

I could go out and walk right in the back door of Kitzmeyer's Drug Store and reach my hand into the peanut machine and get a bunch of peanuts and eat them. [laughter] I think it was probably sometime the next spring that we moved into the offices that we built, the start of Carson Medical Center, which is just west of the hospital on Mountain Street. Dr. Hovenden didn't want in on it because he was retiring, but Dr. Hovenden was instrumental in arranging us a loan with the Nevada Bank of Commerce; I think that's what they called it back then.

This was 1959, and they loaned us a tremendous sum of forty thousand dollars, and we built that building. Cheapest damned thing in the world, but it was better than

nothing. We had to buy equipment. Well, of course, we had the equipment from Petty's office and Hovenden's office.

Did you have to buy into that partnership with Dr. Hovenden?

No. That was just sort of one of Hovie's gifts to me. The idea of a medical practice being worth anything today, and even back then, it is sort of a figment of imagination. People can change doctors too easily, number one. The only thing you'll find maybe is equipment. The good will and stuff like that and the patient records aren't worth anything. If they want to come see me, I can get their records from any place. If they want to go some place else, I'm going to send them to any other place. So why am I buying them? Medical records, I think, belong more to the patient than the doctor, although the doctor is the proper custodian of them.

One interesting thing I did for eight years, starting when I came to Carson City, was to be the prison physician. What an eye-opener that was! They were, for the most part, masters at working you and conning you. At first, they were constantly after drugs, tranquilizers and narcotics. The only narcotics that ever went into that prison were injectable and were with me in my little black bag. And they left with me. It can best be described as hell for the first year. Then, things changed.

How?

At that time, the prison was run more by the inmates than the administration. It took the inmates about a year to really believe I meant my philosophy, which was, if you are sick, you will get good medical care. If you are not, get out of here. This change came more from the prisoners than the administration.

Once the prisoners accepted the fact that if they were sick, they would be cared for, and if not, they would not be, it was pretty easy after that. The con men left me alone.

Shortly after I became prison physician, an execution was scheduled. I was told that all I had to do was to pronounce the individual dead. My curiosity got the best of me, and I went up and examined the gas chamber. I also reviewed the procedure manual, what there was of it. What I saw and read disturbed me. I won't bore you with all the details, but the prisoner was killed by inhaling hydrogen cyanide inside a gas chamber which reminded me of the interior of a submarine. Beneath the chair in a small vat was about 2 gallons of a 50 percent solution of sulfuric acid. A cheesecloth bag containing 16 one ounce lumps of sodium cyanide was dropped into this, and hydrogen cyanide gas is produced. Chemically, it was a risky situation, run by the guards. I had misgivings about taking part in anything that amounted to the deliberate taking of a human life, but I had greater concerns about the real possibilities of a chemical disaster. So I took it upon myself to essentially run the executions. Especially the chemistry part.

I remember one near execution vividly. It brought home a lesson we all were taught in medical school: never, ever play God. The inmate had murdered someone in Las Vegas long before I even came to Nevada. He had exhausted his appeals, and his execution was scheduled. He was a young man, in his mid twenties.

Late in the afternoon a few days before his execution, he was brought to the ER of the hospital vomiting blood. He was unconscious, with low blood pressure, white as a sheet, et cetera. One of the guards said, "Doc, why don't you just let him go! Save the prison and state a lot of trouble and money." It would have taken just a little skillful neglect.

I must admit that I thought about that for a moment, then dismissed the thought, and started the usual treatment. He survived. I gave the governor my medical opinion that the prisoner was physically not well enough to be executed — that has got to be one of the classic oxymorons of all time — and his execution was postponed.

Later, his death sentence was changed to life without possibility of parole. Later still, it was changed again to life with possibility of parole. Just within the last year, I read in the paper that he had been paroled. The thought of making a choice like that never occurred to me again.

As a general practitioner, did you make house calls when you started out?

Oh yes, you bet. I guess I made house calls up until about 1972 or 1973. Now, I didn't make house calls for everybody that wanted a house call. It wasn't house call on demand, but back in those days we took care of a lot of people at home instead of putting them in the hospital, actually terminally ill people. We couldn't do anything for them in the hospital, and they were much more comfortable at home, with the family. As long as the family could sort of hold themselves together — and it's a tough job for them — why, I felt they were better off at home.

I'd make house calls on these people, sometimes two or three times a week. No other reason than to just plant your feet by their bed, smile at them, and tell them how good they're doing, and you both know you're lying. They know what shape they're in. But at least you'd give them a little boost in morale; there's a lot of psychology in medicine. I'd make those kind of house calls, or for elderly people who couldn't get in, and sometimes in emergencies. Yes, I'd make house calls. But

if somebody phoned up at eight o'clock that night and told me they'd had a headache all day, I'd see them in the emergency room of the hospital, but I wouldn't go out to their house.

You quit practice in 1975?

That's when I quit my private practice, yes.

Why did you quit private practice?

Two reasons, I think: one was I couldn't control it. Would you believe me if I told you that the last two or three years I was in practice I averaged a hundred to a hundred and ten hours a week? I couldn't control it. That was one main reason.

How did you balance your family life with that?

Very poorly, very poorly. As far as my family life is concerned, there are a lot of things I did that I regret now. There were times when the only time I saw my kids was on weekends because I was gone before they got up, and they were in bed when I got home. I was the guy that hung around all weekend, and that was wrong. But it's a little bit too late now for me to do anything about that.

Do you think you could have balanced it?

Oh, sure, I could have and I should have. The problem I had was saying no to people that would call up. Should it have been that way? Of course not! But I didn't realize that until it was too late.

The second reason I left private practice was that I started having — maybe I should have seen a shrink or something — but I started having a premonition of death. I kept telling myself, if I don't change, I'm not going to live. Maybe it was all a figment — I don't

know. Anyway, it was there; it was very real to me. And it played a very significant part, and that's why I quit.

What did you do then?

I went over to the emergency room. Another fellow here in town named Jim Fulper was a real first-class doctor; his practice was getting him down. We decided we'd close our practices. We got another guy in with us called Beach, and we started covering the emergency room at the hospital at that time. I covered my practice and got George Hess in; I was sure thankful about that.

Fulper and Beach and I started off on the emergency room in the hospital, and we started twenty-four hours at a pop. In other words, I'd work one twenty-four hour shift, and then I wouldn't have anything to do for two days, and then I'd work another twenty-four hour shift. You don't know what a relief that is.

You actually got more sleep working twenty-four hours?

Oh, sure, yeah. When I say I worked twenty-four hours, I don't mean I was down in the emergency room seeing patients every minute of that twenty-four hours, no. At that time when we first started, we were seeing about fifty or sixty patients a day. They started in at six, seven o'clock in the morning and it would be pretty steady up until about maybe one, two o'clock. Then maybe you'd go get back and you'd get . . . well, say from two to six, that would be four hours when you could sleep. Now maybe you'd have to get up once or twice, but it wasn't twenty-four hours straight on your feet seeing patients, no. Maybe during the slow afternoon you'd get to go back and sit and read a little bit or watch television. So

when I say we worked twenty-four hours, I really mean we were there twenty-four hours.

It was like the internship except that we only saw stuff in the emergency room. We did not admit patients to the hospital at that time. If somebody needed to be hospitalized, then we would refer them to some other doctor in town. That's one of the advantages of being in the emergency room: you don't have the responsibility of long-term care. If we admitted patients, we would work for a twenty-four hour period in the emergency room, and then instead of having two days off, we'd have to go up and solve all of the problems of all of the people that we'd admitted to the hospital. After they're ready to go home, who's going to take care of them then, you see? So we cut our area of responsibility at the time of the admission into the hospital. They were assigned to a doctor then who became their attending physician, not only for the time that they were in the hospital, but hopefully thereafter if everything went all right.

I also worked in the emergency room in Elko. At that time they had a contract with a company out of Colorado. It was the company's responsibility to furnish them with emergency room doctors in the evenings and on weekends, so the other doctors that were practicing in town would not have to cover the emergency room. I got together with this company in Colorado and agreed to go out, oh, maybe one weekend a month and cover that emergency room. That's all I did — take care of patients in the emergency room. If they were sick enough to be hospitalized, one of the local doctors would come in and hospitalize him, and I didn't take care of them any further. But most of the stuff was minor things that you could take care of, and then they could go in and see their doctor or some doctor the following week.

What about trauma medicine; shifting over from G.P. to emergency room medicine? Isn't it a different type of medicine?

I don't think it was so much different for Fulper and I or Beach. It certainly wasn't different for Beach; he was an emergency room physician from the beginning. He came up from a place called Hylands in Oakland, which you might call the knife and gun club of Oakland. It was real busy; lots of trauma.

I'd been doing my own surgery right along, so I had a fair amount of surgical experience. And I'd been working in that emergency room for the last fifteen years; maybe not full time, but each of us had our share of car wrecks and things like that.

What are the problems the emergency room faces today? In many cases they function as a clinic when people with no regular physician come in for non-emergency medicine. Was it truly emergency medicine work when you were there?

Well, there were a couple of doctors, I believe in Pontiac, Michigan, who in about 1968 were the first to start working in an emergency room full time and doing nothing but emergency room medicine. We started in 1975, so it was seven years later that we did it.

Well, the American public was just beginning to catch on to a few things. Number one, if they went to an emergency room, they probably would be seen sooner. Number two, if they had insurance, the insurance most likely would pay for an emergency visit to an emergency room, but wouldn't pay for an office call to the doctor's office, even if the problem was in both instances a common cold. And the third thing that made it grow like mad was that people that didn't have insurance and either couldn't pay or didn't

want to pay found out very early on that they would never be refused treatment in the emergency room of a hospital, because somewhere along the line that hospital had probably received one dollar or more in the Hill-Burton funds, which meant that they had to see everybody that walked through the door. With a setup like that, who needs an explanation of why the problem exists today? The only people you have to try to explain it to are people who aren't willing to face reality.

I used to have people I called five after fivers. These are people that I would see between about five and six o'clock after the office was closed. They were patients of mine, but I'd see them in the emergency room. Why? Number one, they had to work until five o'clock for the state; number two, their state medical insurance wouldn't pay for an office call, but they would pay for a visit to the emergency room. Now, you know, you're out working for a living; you're trying to make ends meet; what the hell would you do? That's so tough for people to figure out? The problem has grown and compounded itself.

It is the same way today. Now emergency rooms have a hell of a lot of costs they have to support. They've got tens and hundreds of thousands dollars invested in specialized equipment which they may use once a month or once every two months, but when they need it, they have to have it. Who's going to pay for that? That's why it costs you five or ten times as much to visit the emergency room.

People ask, why does medical care cost so much? They don't want to face reality. The biggest problem with the high cost of medical care now is with what people are demanding; they just aren't willing to pay for it. I don't know where it's going to go. [laughter] Maybe Clinton or some politicians can figure out how we can have a champagne taste and a beer

pocketbook. I don't know. If they can, good for them. But I'm glad I'm not involved in it.

The problem is people — that's one big change in medicine during my lifetime. When I came to Carson City, the majority of people had a doctor. They would see Dr. Jones or Dr. Smith or Dr. So-and-so; that was their doctor. In case of any problems in the family, that would be who they would contact first. They wouldn't go to the emergency room first; they'd call their doctor first. Now you look around in Carson City and ask the number of people who have one doctor that they look to sort of care or supervise their health care, and I would say probably the vast majority can't give you a name of one doctor. They will fall in two groups: number one is I go to so-and-so for my stomach trouble and somebody else for my heart trouble and somebody for my sore toe and somebody else for my skin problem, and if I ever have a new problem, I'm not sure what I'm going to do, you see. On the other side of the fence is person who really has no allegiance whatsoever to any doctor except the emergency room. Anything that they have along the medical lines, they'll go into the emergency room.

Working in the emergency room up here, I used to have people come in at midnight wanting to get their shots, so they could go travel to China or something. "Why don't you go to your doctor?"

"We don't have a doctor." And they don't want to get one; they don't want to be bothered with it. That's a change in people. Although I don't think that people realize it, I can't help but feel that has lowered the quality of medical care significantly.

Over the course of your practice you saw medical costs increase.

My malpractice insurance the first year I was in practice was four hundred dollars. The last year I was in practice it was fifty thousand dollars. Now what would it be today? Of course, I didn't pay that; the patients paid it. I figured it out one time. I think for every patient I saw in the office, about seven dollars of what I charged went to the insurance company for malpractice. That's one problem that has yet to be solved.

There always seems to be something new that you have to deal with in medicine. What types of treatment or medical problems did you see that you recall specifically? You delivered a lot of babies . . .

Yes. That was fun. I really enjoyed that. One of the big things was to prevent this certain type of bilirubin buildup in the blood in newborns, which caused all sorts of problems. They can handle it very well now. Back then what we would do is, if we had an RH negative mother and an RH positive father, we knew the chance existed for the kid to have this problem at the time of birth. The treatment at that time, if it was bad enough, you would do what is called an exchange transfusion. You took a pint of blood and just sort of exchanged that blood for the baby's blood, which was tainted with all this bad stuff. That's somewhat an oversimplification of it.

Well, I happened to be RH negative, low titre; that's the type of blood that I have. I'm the perfect donor for exchange transfusions. Can you imagine how popular I was not only with myself, but with the other doctors that were doing OB in town? I was the walking blood bank. Every time that any of them would have a problem with RH incompatibility in an infant, they'd get a pint of blood, and we'd go

in and exchange the kid. That was sort of fun. I don't know how many little kids there are alive in this country today that have Grundy's blood in them.

If you had to wait to get a pint of blood from Reno, it would be at least twenty-four hours, and the kid's getting worse. Then when you got it, it was probably two weeks old, which is a big negative; it was fresh blood that was really important. Well, geez, it was about twenty minutes from my arm to the kid. It really worked out slick.

And talk about cooperation, these were things we didn't charge for. I'm not going to charge the mother a hundred bucks for a pint of my blood. For Christ's sake! How cheap can you get?

I did it in medical school. I was a professional donor in medical school. But we sort of had to keep eating then. I didn't need it out here. I was 0 negative, low titre, and for that I got ten dollars a pint in medical school instead of five dollars a pint. In fact, I cheated; I'd give a pint every month.

One of the times my wife was really infuriated with me, I gave her a nice Hamilton watch for Christmas. I had got the money by giving my blood. I forget what I paid for the watch, forty dollars or something, which was a lot of money then. She wanted to know where I got the money. When I told her, I don't think she has ever been as mad at me since she was that I gave my blood to buy her a damn watch. [laughter]

Blood money?

Yeah. Literally blood money. That's the term she used.

Do you think it's possible nowadays to have a single individual provide medical care, or

has medicine become so complex that you, just by the nature of the knowledge, need the specialties?

Well, I not only I think it's possible, but I think that best way to do it is for a person to have a primary care physician, who supervises their entire care. Now, I certainly agree with you that there's no physician today who can possibly learn enough about medicine to take care of anything and everything that happens to people. But I think the responsibility of that primary care physician is to take care of the more minor things and to be a referral source for the patient to the various specialists which he chooses. He knows enough about the problem to understand that, number one, he doesn't have the time, or, number two, doesn't have the ability, or, number three, a combination of both. If he has a good working association with the specialists that he uses for referrals, then he gets information back at his office about what is being done by the specialists. Therefore, he is able to sit to down and look at that patient's whole picture. That's just something the specialist isn't going to do, because you go to your OB/GYN man; he's interested in you from the belly button down. Well, there's more to you than that, you know? So that's why I think the primary care physician is the solution to the problem if people will use him.

But people today say, "Oh, I have a pain in my chest." Do they look up the name of a primary care physician? No. They go and they phone a cardiologist. And does the cardiologist refuse to see him? Well, it's somebody with good insurance, and that's a couple thousand bucks income, you know? What he does is, he goes in and he does all these tests. Then he comes in, and let's say he tells the patient, "Well, there's nothing wrong with your heart."

What's the patient's next question? "Well, why do I have these pains in my chest?"

What's the doctor's answer? "I don't know. It's not your heart."

So that patient goes home and thinks, "Well, maybe it's my back that's bothering me." So they go to an orthopedic . . . You see, not only is time wasted, diagnosis is delayed, and a hell of a lot of money is wasted. That's what people not only want; they demand! Everybody looks at the medical care system as being so horribly expensive, but it's the patients who I think are responsible for an awful lot of the waste. The attitude is, "I think that's fine for everybody else, but not me! If I have a pain in my chest, I will see a cardiologist!"

That's the way people are. I don't know how to change them. The only thing I can say is they better wake up real fast. If that's what they want, they're going to pay for that. There's no free lunch. Even if it goes through the government, there's no free lunch. But people aren't ready accept that, so I don't know . . .

You mentioned government interference in the medical field. What do you mean by that?

Well, the government never really tells you how to practice medicine. What the government does, if they have control of a case, is they'll say, in effect — I've never had any government agent actually say this, you understand, and I don't want to imply that I have. But what they say is, in effect, "Doc, you go ahead and treat that patient any way you want to, but if you expect to get paid by us, you better do this." But they don't call that interference.

Let me give you this example. This happened a number of years ago, but I bet it's still true today. I had a little nineteen-, twenty-year-old girl who was pregnant. She

was married to a soldier who was in Germany, and since she was pregnant, she was staying at home and living with her mother and her family down in Coleville — do you know where Coleville is? South of Topaz Lake, in California? Well, her father worked on a ranch or something down there. These were nice people, but they were certainly not well-to-do or anything like that.

As the pregnancy moved along, I diagnosed twins in this gal. Well, twins, especially twins the first time around, sort of makes you a little nervous! [laughter] The doc — probably everybody else — but certainly the doctor. She had some of the usual complications that you see with twins, especially in the first pregnancy, like high blood pressure and fluid retention and things like that. So for the last month of her pregnancy I felt like I needed to see her a couple times a week to keep on top of things.

I thought, “Geez, wouldn’t it be nice if they moved to Carson City until she delivered.” I discussed it one day with them, with the mother and daughter. And Mother said, “Well, geez, I’d be happy to move.” They could stay in a motel where Mother could do the cooking, and I’d take care of her, and then she’d be right here, especially if she went into premature labor — real common in twins, you know. She’d be right here in Carson City, instead of the long drive down here. It was about December, and sometimes in December and January the whole drive gets longer.

At that time her medical care was being paid by a government program called Champus. They paid for the medical care of women who were married to soldiers, the kids and all that stuff. I phoned up somebody in San Francisco who was in charge of Champus on the West Coast, and I talked to him about it. I said, “You know, these people don’t have

a lot, but if you could pay for their motel bill, why, then Mother said she could take care of her daughter and be right here.”

Well, the question was, would the government go for the motel bill? “No, we won’t.”

“Why not?”

“Well, it’s not allowed in the book.” He was looking in a book.

I said, “OK. Well, if you don’t do that, I think it’s necessary from a medical point to put her in the hospital for a month.”

He said, “Fine. We’ll pay for that.”

You see? OK. That’s my explanation. I’m sure that still goes on today. A lot of the people making decisions like that: they take it right out of the book, have no medical background whatsoever [laughter], and that’s why it’s so frustrating.

On the other hand, where would you go out and hire all of the docs to make those kind of decisions? I don’t know where, either. So, this big change in health insurance — it’s going to come. Group health care is going to come. It’s going to be a generation before it comes, before you get the educated manpower. For the next ten to fifteen years, I don’t care what they do, it’s going to be all screwed up.

What about managed care?

I think that’s probably about the most viable solution that we have today. Yes. You look at Kaiser. Kaiser, I think, overall has done a good job on the West Coast. I really do. I think some type of thing like that where they have a high degree of medical input is necessary.

You were active in medical politics and were on the Board of Medical Examiners ‘69 to ‘80. How were you appointed to the Board?

I was appointed by Governor Laxalt. The governor has the absolute authority to appoint anybody that he wants to the State Board of Medical Examiners, along with lots of other boards. He is not required by anyone to get any advice whatsoever. But since I have been in the state, it was the common practice for the governor of the state, whenever there was going to be an opening on the Board, to contact the State Medical Association and ask for the names of two or three or four or five people from an area, and then he would choose one. That's the way it was done.

That was not the way it was done in my case. Of course, Paul Laxalt was a Carson City boy. Dick Petty was on the Board just before I went on; he left the Board because he left practice and went to work for SIIS or NIC. Therefore, he was no longer eligible, because the law says you have to be an actively practicing physician. I knew Paul pretty well; they had been patients of mine. I phoned up Paul, and I said, "Hey, you know, I'd like to take Dick Petty's place on the Board.

He said, "Dick, you got it!" [laughter] And I was appointed to the Board! [laughter] I might say that ruffled a few feathers in the medical profession, but that's how I was appointed.

Why did you want to take Dick Petty's place?

Well, up until that time, I was very interested in what I'll call medical politics. That is, I was very active in our little, local medical society; in fact, I started our local medical society. I was active in the State Medical Association. I enjoyed it and felt it was part of my responsibility. It was that way with the Board, I just felt that it was something that needed to be done, and I should do it.

I was usually an officer in the State Medical Association. I saw the possibility of

conflict while I was on the Board, and that's when I became inactive in the State Medical Association. I could see where people would want to bring pressure against me to do this or do that.

Now, that's what I felt then. Please don't misinterpret anything here; I'm not saying that everybody should do as I did. Everybody's got to sit and look at their own conscience. I sat down and looked at my conscience, and that's a conclusion that I came to for myself. I'll let other doctors do the same.

Did your experience on the Board of Medical Examiners live up to your expectations? You said you thought it was an opportunity for you to give.

Well, I sure gave, but that's all right. You'll also remember I said the best part about it was I enjoyed doing that kind of thing. That's certainly true. Did it fulfill that enjoyment? Yes, it did. [laughter] It was sort of exciting at times.

It seems to me one of the exciting times would have been in 1973, at a meeting for Dr. Moore, George Moore. The meeting had to be recessed, and according to the minutes, Moore was led from the room in handcuffs, under arrest. Then he was apparently admitted to the State Mental Hospital in Sparks. Do you remember that?

Yes, yes.

Can you tell me a little bit about that?

Well, that was pretty exciting. That wasn't at a regular Board meeting; it was a hearing that was being held by the Board because he had been charged with malpractice. I forget the details, and I'm not so sure they're important. But I knew Dr. Moore in town, and

I had reservations about him. At the hearing his attorney requested that I not sit on the Board, which I think was probably proper. Les Moren was, I think, president at that time, so I asked Les if I could stay and listen. Les talked to Bryce Rhodes, who was the attorney, and they mumbled back and forth, and I might say Dr. Moore's attorney objected and all that stuff. Anyway, it was decided that it wouldn't be anything wrong for me to sit through the hearing, but they didn't want me to discuss anything about the case with the Board during the recesses, which I thought reasonable.

I went back and sat down, and the Board presented their case against Dr. Moore. Then Dr. Moore's attorney got up and started his defense. Shortly after that, Dr. Moore stood up, and, in what was to me a strange and improper manner, fired his attorney and started to represent himself. He opened his briefcase. I was sitting in back, and in his briefcase I couldn't help but see a revolver. I moved up closer to him, quite frankly, because I didn't know quite what to do. But if he was going to start that stuff, I thought, "Well, I'll attack from behind; probably be safer than attack from front," you know. [laughter]

He got one of his defense witnesses up there, and just started badgering this poor little girl unmercifully to the point where Les Moren called a recess. I went up and I told Les about the gun, and then I backed off. The other docs got together, and they decided to call the cops. [laughter] The cops came in and arrested him and took away his gun.

It might have been a potential problem, but it didn't turn out to be a problem. He was taken up to Sparks for a while. Then I really just don't know. He left and went down to Texas for a while; then he came back up to Elko. I don't remember what conclusion the Board reached, if any, at that hearing, to tell you the truth. That was a long time ago, but

that's sort of the story of George Moore. He lived in Elko for a few years, and then, of course, he died.

One of the important functions of the Board is to examine physicians. You told me about your examination process. [laughter] Can you tell me about what it was like from the other side? What types of things you were looking for. It seems to me, from having talked to you and other physicians, you were looking at more than just what the applicant said.

Well, in the first place, when I got on the Board, over the first four or five years, and certainly after I became president, after they had applied and sent in their fees, we would check their credentials to find out if the copy of the diploma that they sent was actually a good one. We'd write the medical school, "Hi. Did So-and-so go do school there?" We'd check their internship and their residencies to be sure that was all true.

At that time the gambling board of the state had a rather large network of investigators whose job it was to go out and investigate people who were trying to get gambling licenses. These guys could come back, and they could almost tell you what kind of toothpaste they use, you know. Not in every case, but in many cases, they would do an investigation for us. We would find out whether the guy was a good guy or not, long before he ever came up for his exam.

Once he came up for his exam — now, by his exam I mean coming in to meet the Board — we'd ask him questions. I'm not sure I can explain how or why, but after a while you could almost judge a person not by what they said, but by how they said it, by their presence while they were in talking to the Board. Of course, some of them we knew that we did not want, based on the background investigation.

Those were the ones that we asked medical questions that they couldn't answer. Then we were very sympathetic that we couldn't give them a license.

Most of the questions were rather simple and straightforward, and the type of things any doctor knew. For instance, what's the dose of penicillin, injectable, in an adult? Procaine penicillin? Well, six hundred thousand units is the usual dose, you know. If they say six hundred thousand units is the usual dose, but, geez, you can give them twelve or eighteen if you want to, well, that's reasonable. That's sort of how they answered it, what they know. But if they say, "Geez, I don't know," [laughter] you might start worrying!

There was one navy doctor — in fact, that's a question I asked him. I asked him, "How do you treat gonorrhea?" He didn't know; he couldn't answer that. I said, "Well, let's say you treat gonorrhea with penicillin. How much penicillin would you consider would be the proper course of treatment for gonorrhea?" Penicillin was the drug of choice at that time. He didn't know. We didn't pass him. Although he was a nice guy! But he'd been in administrative medicine so long, he forgot how to take care of people.

I really don't mention that in criticism of him, because I look at myself today — I don't treat anybody because I've forgotten so much. I've been away from it so long. The closest I've come to treating anybody is phone up a doc that'll see him, you know? I'm no good anymore. Anyway, we told the guy, "You go away for six months and just review." We suggested that he take so many hours of postgraduate work, and we suggested that he go into an internship for at least three months, to have hands-on patient care, then come back, and we would talk to him again. Well, he never came back.

What about somebody who has incredible test anxiety for oral exams? Could you tell the difference between somebody who was just so nervous they're almost paralyzed with fear and someone who maybe had something to hide or was not quite stable?

Yes. The guy who's paralyzed with fear looks paralyzed with fear. The guy who's trying to hide something looks paralyzed by fear, but is forcing such control over himself that he looks cool as a cucumber, you know? It shows. You have to remember, we couldn't arbitrarily accept or turn down any of these people. The oral examination that we had was just one part of the requirement, but it was an important part.

This is a hypothetical example. We would have an alcoholic from Kansas City, Missouri, who was coming in for a state board license. We already knew he was an alcoholic; he'd been disciplined by the hospital where he worked a couple times, and stuff like that. We wouldn't say, "We're not going to give you a license," because he's an alcoholic. We'd ask him a question, a medical question, which he couldn't answer, and we were sure sorry that he couldn't answer that question, and that's why we couldn't give him a license. I don't have to tell you how much better the liability is there. I doubt if they do that now, but back in those days it held up pretty well. We were challenged once or twice, and won every time. So it worked then.

What if you got a physician who did have an alcohol or drug problem that successfully completed rehab?

Well, successfully completed rehab — I think we would have been highly dubious about him if he was out here the day after he successfully completed rehab. Now, if he

successfully completed rehab and then went out and practiced for a couple years without getting into any trouble, we'd probably look on him favorably.

I'll tell you the story of one that we blew. [laughter] I guess it was my fault that it was blown, because I think I talked the rest of the Board into giving this guy a license. This was a guy who was a convicted felon from some state back east — Indiana or Michigan, something like that. He came out to Nevada, and he wanted a license. We talked to him at some length, and really, it seemed like he knew medicine pretty well. But here was this conviction.

Well, he'd served his time, and for some reason they gave him back his license back there, which is unusual. He'd gone back into practice and been clean for a couple years, then wanted to come out to Nevada. At that time the prison needed a prison physician. We made this deal with him: if he would become prison physician for three years, we would give him a license that was restricted only to treating inmates at the Nevada State Prison. After that three-year period of time, if he didn't have any trouble, we'd go ahead and remove that restriction. That's what we did, and he was a good guy out there for about a year. Then he decided he wanted to just be a psychologist instead of overall general physician, so they said that he could do it out there, and they hired somebody else to practice medicine.

Over about a period of the next couple years, I think he became more mentally deranged than any of the patients he was seeing out there. At the end of the three-year period of time, we refused to give him his license, and he took us to court on that. At district court level the Board was upheld. He was going to appeal it to the Supreme Court, which, as far as I know, he never did. We just

didn't hear any more; I don't know where he went. [laughter] That was a mistake; that was a mistake.

How much do you know about their background? For example, if someone is convicted of a felony, do you know the details of conviction?

Yes. He had a thick file, and I read every word of it. Yes. This particular person was the driver of somebody who ran in and robbed a Seven-Eleven type of a store. Nobody was killed; no guns or anything like that. He was the driver. Of course, he said, well, he didn't know the guy was in there robbing them; I don't know. Anyway, he was an accessory to the crime, and they convicted him, and he spent his time. I don't know, I guess I got up that morning on a sympathy jag or something like that.

The Board took a lot of time, didn't it?

Yes, but I enjoyed it. The most amount of time it took for me, since I was the doctor in Carson City who was on the Board — what really took my time was when the legislature was in session, because then I sort of became the Board's lobbyist. I'd go down and talk to legislators. At that time we didn't have any organized political program, but there would be a few little things that we'd want to get done. I'd just go down and talk to them. They were usually pretty reasonable.

One sort of interesting one, which still tweaks my nose and makes me halfway mad at the legislature, and I don't mind telling you about it, is acupuncture. I was on the Board at that time, and in about our September meeting, Joyce, the big lobbyist from Las Vegas, came up to our Board meeting. He had a Chinese doctor with him; I don't remember the name. Joyce wanted us to give this doctor

a temporary license for the month of January, so he could go down and demonstrate acupuncture to the state legislature. He said, “Well, we’ve got all these credentials.”

This doctor got up with this diploma that he had. I guess he’d gone to medical school. It was a thing about half the size of that wall! It looked like these Chinese pictures [laughter], you know, with some Chinese writing on it! [laughter] I didn’t know whether it is a diploma or a billion-dollar bill, you know, from looking at it! [laughter] We explained to Joyce, “Well, we’re going to have to have this translated and find out what’s going”

Joyce said, “No, we don’t have time for that.” The Board finally had the guts to tell Joyce that, no, we’re not going to give a license. I was the one that told him that. I never will forget; I was sitting in the chair, and he was standing up, and he looked up, and he said, “Grundy,” he said, “he will have a license to demonstrate acupuncture in January; I guarantee it,” and walked out. And he did. Joyce got the legislature to pass the law to give him a license to demonstrate acupuncture to the legislature during the month of January. That’s how much power that man had. Somebody had paid Joyce to represent this acupuncture cause. I don’t know who; I’ve heard various stories, but I really don’t know for a fact who it was.

The thing that really ticked me off about the legislature was the attitude at one of the committee meetings on acupuncture. I went in to testify. Instead of dressing like I am today in a flannel shirt, I had on a suit and a tie and everything, and I thought, “Well, at least I look close to a doctor” — probably even got my hair cut; I don’t know. My turn came, and I got up and sat down, and said my thing. It was a joint committee meeting of both the senate and the assembly. There were fourteen, fifteen of them, half of whom weren’t there.

They were out walking around. It’s a sort of a hoop they got to jump through in order to get the job done.

I gave my bit, and asked if there were any questions. No questions. I got up to leave, and I went back and sat down for a few moments. The next person they had was some acupuncturist from San Francisco. This guy came in; he was a guy about forty years old; he was Asian. He had sandals on his feet, no socks. He had on the scruffiest-appearing blue jeans held up literally by a rope for a belt, and had on a T-shirt that’d sort of been dyed all these colors, you know — you’ve seen some of them. He had hair all over his head, beard and everything, which was totally unkempt. He went up and sat down and started to talk, and every legislator was in their seat listening to him.

And I thought, “Boy, there’s something wrong with the process!” [laughter] Because to be honest with you, not half of them listened to what I said, and the half that did, didn’t pay attention. I don’t have to tell you that acupuncture passed, and Joyce got his X number of dollars.

I don’t know who was behind it. I’ve heard one story in particular about three times, but that still doesn’t make it credible. What the hell, we have it now. And really, I must say, over the years it hasn’t turned out to be the disaster I thought it was going to be. It had its sort of flash in the pan, and then has relegated back to a reasonably proper spot.

What was your objection to it?

Well, it was sort of an unscientific medicine. We didn’t know anything about it. And still don’t, not that I know of. It is being used mainly in some teaching centers, and seems to be effective, but I’m not sure if anybody knows why. However, just because

you can't explain it doesn't mean that it's not possible.

I think it isn't being used by everybody for everything like it was at first. I had patients who underwent a significant amount of damage from acupuncture. I remember one guy; I don't want to describe him too much, but he had some back pain. He went and saw this acupuncturist, who put needles in his hip down here, and then applied some electrical current to them. Somehow he got close enough to the sciatic nerve just to burn hell of that guy. He's still around; he still limps, you know, from the damage to that sciatic nerve. On the other hand, I have had other people who have said that it has very definitely relieved their pain, where I didn't. So I'm not willing to say it's all a bunch of baloney, but medicine accepts things quite slowly. And I can't help but think that's probably a pretty good idea.

While you were on the Board, you dealt with problems with foreign medical school graduates.

Yes. This is probably the most fascinating story that ever happened when I was on the Board, and it relates to that. When I first came on the Board, one of the first things that I questioned concerned a doctor who was working in an emergency room in Las Vegas. He had been working there for several years under a temporary license. Although I was new on the Board, I had, busy me, read the law. I said, "Well, it seems to me that the use of temporary licenses was designed by the legislature to allow doctors to come into the state for a short period of time whose skill and expertise was necessary. Or for residents to come into the state for training purposes and things like that." A temporary license was limited to one year, and in this

guy's particular case, they were just sort of renewing it every year. I said, "Why don't we just give him a permanent license?" The reason that we couldn't give him a permanent license was because he had gone to medical school in Mexico, and at that time the law said in order to be granted a license to practice medicine in the state of Nevada, you must have graduated from a class A medical school in either the United States or Canada, period. I said, "Well, that means he is never going to get a permanent license.

"Yes, that's right."

"You mean, we are going to keep giving him temporary licenses?" That seemed wrong to me, sort of making an end run around the law. So, anyway, we agreed we would give him another temporary license for another year. But during the next year, or maybe it was two years, the Board got together for a two- or three-day meeting, and we did nothing but discuss changes that should be made in the law. We ended up just completely re-writing the Medical Practice Act. We got it pretty much the way we thought it should be. One of the changes we made was . . . I forget exactly how it was worded, but we removed that restriction that you had to graduate from either the United States or a Canadian school. Any school would be acceptable if it was a good school — that's sort of a loose way of putting it, and I don't remember the more exact words that we used.

The legislature met, and I went down and shook everybody's hand and stuff, and they passed it, so we now had this new law. We went back, looked at this guy's credentials, and they were all good. One of the members on the Board at that time was a surgeon from Las Vegas who was chief of surgery in the hospital where this guy worked as an emergency room physician. He had nothing but glowing praise. He was a good guy. The record that we had

was all right, and so we decided that we would go ahead and give him a permanent license.

I talked to him three or four times, and, I must say, he seemed like a reasonable guy to me. He told me about his life, and said he was born in Louisiana of an old and rather aristocratic family. He grew up with sort of a golden spoon in his mouth and went to the University of Louisiana, where he graduated with all of his pre-medical credits accomplished. He was then admitted to the University of Louisiana School of Medicine in New Orleans, which is right next door to Tulane. They're practically the same school, and he went through his first year of medical school. During the summer, Huey Long came into power, and when the kid went back for his second year of medical school, they didn't know anything about him; they had no records of him. He went over to the University of Louisiana; they had no records that he had ever gone to the University: "I don't know where you got that diploma, but it must be a forgery because we don't have any records of you ever going here." He said that this was because his parents had been members of an aristocratic and agricultural family, and, of course, dead-set against Huey Long. This was, as he put it, the way Huey Long said, "Thanks."

He said he hung around in New Orleans; he became interested in Jazz. He liked to play the clarinet. He was a good clarinet player, we heard him, but he really wanted to go into medicine, so he went down to a medical school in Mexico City. Now, at that time there were three medical schools in Mexico City: two of them dumps and one of them good. He went to the good one, and that's what his diploma showed. Then he spent two years of servitude in Mexico, which you're required to do, at least at that time, and then he came to the United States and started working at the emergency room in Las Vegas. That was his background.

About three to six months after we had the law changed, we had our meeting down in Las Vegas, and we thought it would be nice to hand him his permanent license at a meeting instead of just sticking it in an envelope and sending it to him. It would mean quite a bit to him, but we didn't know how much. We asked him to come to the Board meeting, which scared him, and I really didn't know why. I might say, during this period of time I went down and spent about six or eight hours with him working in the emergency room where he worked in Las Vegas, and he did a good job.

So, anyway, we had our meeting down there, and we asked him to come, and we told him we were going to give him his license. Well, then he breathed easier. He came in the afternoon, and we had a little ceremony, you know, and gave him his license all signed by us. He said, "I want to show my thanks to the Board by taking you all out to dinner." I thought, "What for, you know, what does this guy owe us?" Really, we didn't change the law because of him, we changed the law because we felt that the law should be changed.

Well, what a dinner it was! I've never been to one like that before or since. It was in a sort of a banquet area in one of the big hotels down there, there was a private bar, the meal was gourmet plus, there was a band there, and this guy played the clarinet. It was all the Board, plus Bryce Rhodes, and we were all down there as men, and when we showed up to meet him or at dinner, there was a lady for each one of us. I've never been treated that way; in fact, I didn't quite know how to act, to be honest with you! And that even reinforced more, "Why is he doing this? What does he really owe us?"

Anyway, a good time was had by all and everything, and another year or so went by. I don't know why, but this seemed to stick in the back of my head. By now I was president

of the Board, and the Board got a letter, an unsigned letter. The letter said in words to this effect: "You should check out this doctor; he never even went to medical school." That hit me so hard I phoned up Bryce Rhodes, and I said, "I want you to get on a plane, and I want you to go down to Mexico City, and I don't want you to come home until you can tell me that either he went to medical school and graduated down there, or he didn't," and Bryce did. He came back a week later — I think he spent about two days finding it out and just had a good time the other five — but, anyway, after this guy had reportedly gone to that medical school, the medical school had a big fire and all the records were burned. But Bryce took along a copy of his diploma which we got from every applicant, an actual copy of the diploma from medical school. The registrar at the Mexican medical school examined the diploma and finally pointed to the date of the diploma, which was the date of graduation, which was two days different from the date that they had actually had their graduation. Which means the diploma was a forgery, a very good one, but it was a forgery.

When I found that out, why, of course, we arranged a hearing for this doctor. He hired one of the better attorneys down in Las Vegas who — well, maybe I should not use the word — but I will say harassed us for about six or nine months, you know, delaying things and delaying things and delaying things.

Finally, the hearing day was set. No more delays. The afternoon before we were to have the hearing, this man's attorney flew up from Las Vegas. He came into the Board offices with the guy's license and a signed letter, saying that, "I hereby voluntarily surrender my license to practice medicine in the State of Nevada," signed so-and-so. And have not heard a word about him since.

He just disappeared?

He just disappeared. I guess I will go to my death bed wondering about him. Where he got his medical education, I don't guess we will ever know. He was thought to be a good doctor by good doctors who were close enough to know. But fraud is fraud. He was a single guy, I guess. I never met a wife or anything. Of course, a party like that, God, it was a good thing my wife wasn't along! But that's [laughter] probably the most interesting story that I can relate. Here we gave a guy a license to practice medicine who had never been to the medical school.

Did you have an influx of foreign medical school graduates when the law was passed?

Yes, we had quite a few. Most of them were good. Well, I like to think all of them we gave licenses were good! [laughter] Some of them we didn't accept. When we set it up, we also added that they had to have at least some training in this country, things like that, and with this guy we accepted his years of working down there in the emergency room as his training in the United States.

They had to have, I believe, a minimum of two years of training in the United States. That way we could write to the hospital in Seattle and find out what this guy had been doing the last couple of years, how he did up there. We got mighty good doctors that way. The doctors that really impressed me the most were the doctors from South Africa. Boy, you would ask them a question, and twenty minutes later you had to tell them to stop talking. Not only were they bright and well educated, but when you asked them a question, they would answer it in a wonderfully organized manner, just like you could write an outline from their answers. I don't think we made a mistake there. They

were the best. Although there were some that were pretty bad. Grenada! Of course, that's a diploma mill.

They are still fighting the diploma mills in the Caribbean, aren't they?

Yes, and in a way I feel sorry; I really do. There are some diploma mills in Mexico; at least there were back then. These kids go down there and give three, four years of their life, and a lot of money, a lot of money, and they come up here with this diploma, and it isn't worth the damn paper it's printed on. A lot of them don't do it thinking they're trying to put something over on somebody. They are doing it because they can't get in to the medical school here, so they go down there because they really have a strong urge. They want to be a doctor, and then four years later, you say, "Sorry!"

In a way they are innocent, innocent victims. Some of them knew what they were doing, but most of them didn't. Geez, I remember more than one of them going out in tears, never having a chance, at least in Nevada. I don't know what they did.

How did you determine what is a reputable foreign medical school?

The AMA helped a lot. We used to write letters, and we'd find out. The AMA can tell you where every member of the AMA graduated from medical school. If this doctor graduated from Podunk U. in India or someplace, we'd go to the AMA and say we'd like the names of ten doctors who graduated from Podunk U. in India you know, and we'd write them. We had an investigator go out and talk to them and find out what their medical education was like.

Probably the best safeguard we had was in requiring they have two years of postgraduate

education in this country, and it wasn't just working; it had to be in a structured residency program. Well, in a structured residency program, the guy that's running the program can give you a pretty good idea of the guys that are under him going through their residency. That was probably the best evidence we had.

Something that comes up every once in a while is the idea of an umbrella agency to serve in medical examining process. One agency overseeing M.D.'s, D.O.'s, dentists, nurses, all these allied medical fields. How do you feel about that?

Well, I think I am opposed to it. I am like what 80 percent of the rest of the people in this country are — skeptical of the government. That's all we need in the state of Nevada, another super agency. Back then I felt pretty much the same way.

While I was on the Board I can think of only one problem that we had, and really it was not that much of a problem. One of the guys on the Board was out to get this other guy, but that didn't amount to a hill of beans, I didn't think. I think he was a doctor of osteopathy who was practicing in a small town of Nevada. He had received his education and his license from the state of California in osteopathy and then reciprocated it to the state of Nevada by going through the osteopathic board.

In the sixties, somewhere along in there, California decided to get rid of osteopaths. They passed a law saying we are not going to have any more osteopaths; we are going to give them all M.D. degrees. I think they rescinded that now again, I don't know.

This guy felt that since he graduated in California, and since California had told all their osteopaths over there that they were now M.D.'s, that he could be an M.D. in Nevada. So he used to sign his name Bill Smith — that's

a fictitious name — Bill Smith, M.D. That is illegal in the state of Nevada, to write your name and put M.D. after, with the idea of convincing somebody that you are a doctor.

It just seemed to rub this one guy on the Board the wrong way, and he would always have our secretary write the hottest letters to this guy. This guy just ignored him, and I must say, he was a pretty good D.O. He was out in a small town. The rest of us on the Board said, “Hell, why don’t we just leave him alone,” [laughter] but this one guy — we’d just get tired of arguing about it.

I don’t know as it’s any advantage to combining them all. When I was on the Board, if we wanted information about some other board, we always got it, no problems at all. Certainly the State Board of Medical Examiners and the pharmacy board worked together very, very closely — very closely, which of course they should. As far as dentists are concerned, I can’t remember any problems. We did have some doctors who had medical licenses, as well as dental licenses; of course, they had been through both schools, so why shouldn’t they? I don’t know any problem ever created.

So, if it ain’t broke, why fix it? I get awful nervous; I’ve lived and worked in Carson City long enough to observe several empire builders at work. I sure don’t favor it; that’s an ideal setup for an empire builder.

One problem we always had with the Board until about 1975 was getting information from other state medical licensing boards about doctors who wanted to come to Nevada. At a meeting of the Federated Organization of United States Medical Board, or some flowery name, we were told that the medical boards would start sending the other medical boards information. I think now the federal government had gotten in little bit in helping with that process, but at least they haven’t

taken over the licensure of the physicians across the country. I don’t think that should happen. We are a long way from Washington, and I would hate to think that doctors in this state had to look to Washington D.C. for licensure.

I think really it is working quite well right now, and while it might work that other way, why change it? It isn’t hell of an expense. The Board, I don’t think, gets any state money; they operate on the money; they charge me every year, every two years or something, to renew my license. I can tell you this, if the federal government ever started in, it would cost me ten times as much to keep my license active. [laughter]. Well, I’m not in favor of that.

What about the issue of Continuing Medical Education?

That is one fight I had with the Board. At one of the legislatures, I got into with — well I wouldn’t mention his name because he is still down there. He is one of the long-timers, old-timers, and he introduced the bill to require doctors to have postgraduate education as a condition of renewal for their licenses. I went down there and talked him out of it. I said this is really the Board’s function, and he said, “OK, Grundy, I will pull my bill, but,” he says, “in the next two years I want the Board to do something about this.”

I could never talk the Board into it, and at the next legislature after I left the Board, the Board did not pass it; the legislature passed it. I still think that is an example where the Board shirked its responsibility. They didn’t want to do it, because they did not want the criticism from the doctors around the state about how the Board was making them to go to all these meetings.

Why were the doctors not in favor?

I think a lot of them felt that they just didn't want the Board telling them what to do. But it was still a good idea. Let me tell you this story; this is a perfect example of why I think CME was necessary. We had a doctor in a small town in Nevada. He was the only doctor in town and had been there for many, many years, twenty, thirty years. A very dedicated guy, he was always available; he had a little hospital there and was always available to take care of everybody. The old G.P. type like I had wanted to be.

He came up before the Board because of medical malpractice, for mistreating of people. We had a hearing to take away his license, and we talked to the guy. In talking to him we found that since he moved there, twenty, twenty five years before, he had never gone to a postgraduate course. Now, he had not taken any other vacations either; he didn't choose between that and going and playing in Hawaii. It wasn't that. He really was too dedicated and stayed in that little town, and he took care of people. The problem was, by the time of his hearing, he was taking care of people the way he took care of them twenty years ago, and medicine marches on.

We revoked his license, suspended his revocation, and we said, "For six months, during this period of time, you must take three months of in-hospital training and complete, I forget how many hours of postgraduate training, and then you come back and we will talk more."

I helped him find training down in Sacramento, and when he came back and talked to the Board, he said, "I want to thank you all. I didn't realize I was so far out of date. I am here to prove it to you."

We asked him a bunch of questions, and now he was sharpened up. He was no dummy,

and he went back to that little town and practiced for about another five or six years, good medicine, and died of a heart attack.

Now, if you have to pass a law to make that doctor or any doctor get postgraduate education, then I'm for it. Even I still get my postgraduate education. I get it because it is a legal requirement.

Do you still keep your license?

I still keep my license, and I have to do CME in order to keep my license. If you asked me why I am keeping my license, now I would have to say, "I don't know." Unless it is pride, because before I would lay hands on anybody, I would go and take six months to a year of training. I am that far away from the main stream, you know.

I would do that whether the state said do it or not. Not only do I have to learn this stuff, but just as importantly I have got to have the confidence in myself that I can go out and treat a sick person and do it right. I don't have that confidence anymore.

But there were a lot of doctors in the state of Nevada that never took any postgraduate work. They do now, and does it work all the time? No. For instance, right now I go and I get my twenty hours of postgraduate education every year, and I'm first to tell you when I go down to a course, I go and I sit down and sort of lean back and listen, and I don't pay a hell a lot of attention. Where before I was sitting down and taking notes and notes and stuff. I don't plan to use it, but I am willing to put up with that for the benefit of the whole, and I think it is a benefit for everybody to do it.

What do you think about midwifery? The Board took a position that being a midwife was practicing medicine.

Well, I don't know what else you call it.

How do you see it fitting into medicine at this point in time?

I don't think midwifery should be allowed unless it is under the direct and total supervision of a licensed physician who also knows what he is doing in obstetrics. It's sort of like the physician's assistants that we have in the state. According to the law, they should be very closely supervised. Now, I would have no objection to a physician's assistant to an OB/GYN man, who did a lot of things, including deliveries, under the direct supervision of her monitoring physician. What I object to is somebody with less than an M.D. degree, setting up shop in Tonopah and saying, "Ladies, I am a midwife. See my certificate on the wall? Come to me, and I will take care of your pregnancy from conception to delivery."

I think that is wrong, because I know what happens when the fat gets in the fire. That's one of the exciting things to a doctor, at least, about obstetrics. Boy, things change in a hurry, and you can go from everything just being swell to a disaster which you have to cope with. I remember one instance with a midwife: her idea of coping was haul it in and drop it in my lap. It should have never gotten to that disaster point, and if she knew what she should have known, it would not have happened.

So that's my feeling on midwifery. I have no problem if they operate under very close supervision of their physician, but to turn them loose as independent practitioners? I think that's a disaster waiting to happen.

What kind of impact did your association with the Board have on your opinions about

medicine and your fellow physicians? Did it affect your view of other physicians?

No, no, I don't think so. No, not being on the Board, I don't think did that. If they were local and they were bad guys, I knew it before they came to the attention of the Board. Like this recent case in town of the dentist sexually molesting his patients; he was also an M.D. Now, making no comments about his guilt or innocence, I can say that I can see how that could happen in a doctor's office. That is something that I might be aware of as a doctor here in town, whereas as a member of the Board I would not be aware of it. The Board members don't run around like police.

I think my years on the Board maybe made me a little more conscientious as far as details like book work, which we all hate.

Don't you have keep immaculate records for narcotics?

Yes. Now I will tell a funny thing that happened when I was on the Board. This was after DEA took over the drug enforcement in this country, which was back about the middle seventies, I guess, when drugs were mushrooming into a big problem. The federal government hired a bunch of investigators. They were really hot to trot, and they were always on our back for some of the most silly stuff. I will give you one example.

There were three doctors in a clinic down in Las Vegas, ear, nose and throat specialists, who were good doctors, real good ear, nose and throat specialists. The fed narcs came into a Board meeting one time, and they had all their evidence there. They wanted us to take these guys' license. You know why? Because they were using cocaine in the nose as a local anesthetic, and they were not writing

everybody's name and dose down in some damn book. And we were supposed to take away their licenses. The best topical anesthetic to this day is cocaine, and in the emergency room I have used a fair amount of cocaine for bloody noses. It shrinks it down, makes it easy, and it works great. There is nothing that approaches it.

Now, I'm not in favor of the other uses of it you know, but to take these guys' licenses away? Dumb, you know? My comment to them was, why don't you go chase the bad guys, leave the good guys alone? They walked out sort of with their tails between their legs. It's stuff like that. They used to irritate me.

I remember one time they came into my office, and I guess you've heard that doctors' handwriting is very poor. Well, I'm the perfect example of that, and this narc guy had been around to drug stores, and he had collected a stack of prescriptions about so high. He says, "Your signature is illegible." Said, "The law plainly states that you have got to sign your narcotic prescription in a legible manner." And then he made a big mistake; he said, "No bank would accept that signature on a check." I reached back and I pulled out a stack of checks, and they were all signed the same way. He got up, scooped up all the prescriptions, put them in his briefcase, and out he went. I never heard another thing about that.

It's ridiculous stuff like that. I should have written them more illegibly, I guess, but I'm sure the guy has a full-time job, going around discovering picayune things like that. Maybe he can't make a living someplace else, or maybe it's the government's fault for going out and finding the guys like that. I guess we've got to have it with the drug problem in this country.

Do you have any final comment that you would like to make about your view of medicine, your

view of the Board? The final words of Richard Grundy, as he looks back on three decades of practicing medicine?

Well, I think, the only comment I would have to make now is that I have made enough comments.

[laughter] That's a good way to end.

Yes.

THOMAS HOOD, M.D.

Dr. Thomas Hood was born in Elko, Nevada, in 1921. His father, A. J. Hood, was a family practitioner; there have been six “Dr. Hoods” who have practiced in Nevada, dating back to the nineteenth century.

Dr. Hood attended schools in Elko, and graduated from high school in 1939. He received his undergraduate degree from Pomona College in 1943. Joining the navy after graduation, he obtained his medical degree from Washington University Medical School in St. Louis, in 1945. He served his internship at Shoemaker Navy Hospital in California, and he completed a three-year surgical residency at St. Joseph’s Hospital in San Francisco, California.

Dr. Hood returned to Elko in 1951 and joined the Elko Clinic, where he practiced until his retirement in 1982. He has been active in community affairs, working with the Northeast Nevada Museum, and a convention center and auditorium in Elko.

Thomas Hood, M.D.: I was born here in Elko in 1921. My father was a physician, Dr. A. J. Hood, who arrived in town in 1903,

from Michigan, to practice with his brother, Dr. Charles Hood. Charles Hood had been here since the 1890s, I believe. My mother was from an old local ranching family, the Hunters. Her grandfather was actually was buried here.

I had a sister who died as a child of pneumonia, before I was born. Then I had a brother who is eight years older than I. He was off to school; he went down to prep school in San Rafael and then on to college, and so I really didn’t know him well. I loved to see him; I thought he was great, but there was quite an age difference. I had another sister who was two years younger, and we were quite close.

My childhood was spent here in Elko. I went to the Elko Grammar School and then to the Elko High School and graduated in 1939. I really had a great childhood, I thought; but probably I was not an ideal child. [laughter] We loved to get out in the country and fish. [laughter] We certainly enjoyed the climate here.

When I was small, the first I remember, the population of Elko was two thousand.

I remember going back to University of Michigan, where my father graduated from medical school. Oh, I guess it was about 1928 or so, and he took us out to the football stadium there, showing us the stadium. This was quite something for a kid from West to go out and see all those seats. He said, "Look at this. See all those seats? You could put the whole state of Nevada in here and have room left over." [laughter] I will never forget that. And that was right. There were something like, as I recall, ninety thousand people in the state of Nevada at that time. The stadium would hold ninety-five.

Anita Watson: What was it like being the son of a physician practicing medicine here in the 1920s and 1930s?

Well, my father was always quite busy. I guess that you kind of felt you had to live up to your father's expectations. [laughter] He was very respected here, I think. The thing that I remember most about the early 1930s was the Depression. And as I look back on it now, boy, it was pretty tough times. Gee, you know, being the son of a physician, we never wanted for food or necessities. We really had it pretty easy.

Do you remember some of the impact of the Depression on Elko? You were old enough to remember what it was like before and then during?

Oh, yes. I can remember the day the bank closed. When you went down to the Henderson Bank here to get the money out — it was all closed; you couldn't get it. People were really quite desperate. And, of course, there was very little cash then around. The thing that kept Elko going — I can remember my mother saying this — was that the Western

Pacific Railroad had shops here, and they had a salary that they paid regularly. They hired, oh, several hundred people here, and that seemed to keep enough cash in the town to have some cash flow. The schools . . . the county school district was completely out of funds, and they would write scrip to the teachers at the end of the month: "We owe you some dollars." Strangely enough, the merchants in town accepted that. Then when the money was available, they all got paid. So it worked out quite well.

When the bank folded, the Henderson Bank, the Henderson Bank Mortgage Corporation, took over all the assets. I was familiar with that because my father was a director. Around here there were a lot of ranches that had been mortgaged, and when things went bad, why, the bank had to foreclose. So they owned lots of ranches, and as times got better, they would sell these off. Everybody who had money in the bank eventually got it out, plus some more.

It was pretty tough times during those days. As a kid all I remember was having holes in my shoes, and I'd put newspaper in them, and that was all right. [laughter] I didn't think anything about it. But I think that the Depression probably injured people around here a little bit, so that it came out a little better in the end.

You didn't notice people leaving town, or were you aware of that?

No, not too much. Where would they go? The railroads came through here — both railroads, Western Pacific and Southern Pacific — and they ran freight trains down there. You'd go down there, and there would be a hundred and fifty men on each train. We'd call them hobos now, but they were men that were out of work and just seeking somewhere

to go. There'd be all those trains loaded back and forth, and every boxcar would have men on them.

Did you have a hobo town down by the tracks?

Yes, they did. They called it the jungles. It was down by the river near the Western Pacific Railroad shops, which are now just this side of the county jail. The shops, now Union Pacific, are moved to the other end of town. But there were the shops down there then, and the hobos would be down there and have their fires, and they'd come by and ask for something to eat.

Were they distrusted in town or just accepted as down on their luck?

Well, they were kind of accepted as down-and-outers. I remember my father coming home and telling me he had talked to a man here who was the superintendent of the Eastern Division of the Western Pacific Railroad, Harry Beam. They had their offices down there, and there were always men getting off the train. Harry Beam said, "Every morning I would go out and get a dollar's worth of dimes, and by noon they'd be all used up — a dime here and a dime there." You know, people asking for something to eat. I can remember having people come by and knock on the door and asking my mother for some work they could do for food, and she very often would give them food.

You had something of a transient population with the hobo camps?

Yes. But as I say, as far as people packing up here and leaving, I don't think so. The country around here, it's changed a lot. You know, it was pretty rural here. There were a

lot of ranch families around, and in those days the ranches were smaller than they are now. They would be quite self-sufficient. A little family would live out on the ranch; they would grow their own vegetables and their livestock and live off that. Actually, when I started high school, there were some children in my class who rarely got to town; maybe once a year was all. I remember especially some from up north around Charleston, which was a long trip in those days.

How about your family? Did you travel much? If you went out of town, where did you go?

Well, I suppose really we traveled about as much as anybody. My mother had a sister who lived in Oakland, California. My father was a division surgeon for the Western Pacific Railroad, so we had a pass. Our family could travel on that pass anywhere on the Western Pacific Railroad, so we fairly often went down to visit the Bay Area. Essentially that was like my second home. We'd go down for a week or two.

What did you think of the contrast between going to Oakland and living in Elko?

Well, you know, it was always a treat for us kids. Gee, that was great! [laughter] To get on the train and go to Oakland; that was kind of a real treat to go down there for a week or two. I don't know; I look back on that; and I think it must have been terrible for my aunt and uncle down there to see us kids come, the two of us, my sister and I, coming down. [laughter]

As I said, my sister was two years younger than I, and we were great pals. She was a doctor, too. She went to Pomona and then went to the Stanford University Medical School and practiced. She was a resident

in internal medicine and did some practice down around the Bay Area. She married a lawyer down there who was from Elko, and they lived in Alameda. But she died here, oh, it must have been twenty years or twenty-five or thirty years ago.

Did she just practice part-time?

Yes. She had a family then, so she really didn't practice an awful lot.

Did you always want to be a physician?

I suppose. I don't know; when I was in high school, I thought: "Gee, you know what I want to be? I want to be a doctor in the navy." As time got on I thought, "Well, I think I want to be just an officer in the navy."

So my dad talked to Senator McCarran to see about getting an appointment to Annapolis. He said, "Well, I advise you to go over and get one year of college, and then let my office know, and I'll see about an appointment." He also said, "I advise you from a small town to go to a small college," and that's why I went to Pomona College. I'm not sure, I think maybe Senator McCarran was thinking maybe I'd go to Reno, you know, which would have been fine, too, but my mother thought I ought to go down there. [laughter] Anyway I went in and decided to go pre-med, and so after my first year I got a telegram (this was during the war) from Senator McCarran — or my dad did — which said, "Does your son still want to go to Annapolis?"

By that time I'd put in a year there, and I thought, "No, I'll keep on." [laughter] That's the way I went into medicine. But that's what I first wanted to do was be a doctor.

But not necessarily a doctor like your dad, if you were thinking about the navy? Did you want to see the world?

That's right. I thought that would be great; you know, you'd get all around the world and see all these things. [laughter] I had my mind changed towards the navy for a while.

Why did you choose surgery? Or did it choose you?

Well, yes, it did. You know, one thing my father said, "You ought to think about being a surgeon. They seem to have a little more influence than you and I." And you know, I kind of like surgery. Something to do something about right away. In those days we had the general internship. I had surgery and internal medicine, and during that time I had pretty well made up my mind that I wanted to go into surgery after seeing the work.

I got married my last year in medical school. In a way the war was very good to me. It was a real break for me, because when I got accepted to medical school, they said, "Well, now you've either got to go into the navy, or you've got to go into the army, or you've got to go to the Draft Board." And so I thought that was fine: I went in the navy. They paid my tuition to medical school; they gave me a salary and an allowance, and bought all the books and supplies. It wasn't like kids nowadays who have to come up with a lot of money to get through medical school. That was all taken care of. I'm forever grateful to the government for doing that.

Then did you owe them?

Well, yes, I did. When I graduated in 1945, the war ended, and there wasn't the need for doctors, so they were going to let a lot of them out. They said, "You're interns, and you can do one of three things: you can get out now (this was about April, I think it was, of 1945); you can stay until July first, which would give

you a full year internship (that sounded good to me, so that's what I did); or you can go over and sign into the regular navy."

Well, I thought I'd want a full year, so I said, "I'm going to go July first." Well, about May twenty-second — I will never forget that date — the navy issued an edict. All who'd been to V12s, that was the training program for the medical school, and who were interns, would have to stay in for two years more. But that was great, when I look back at it, because some of my intern classmates got out. And then they went into a residency, were out practicing, and then came the Korean War, and back in to the navy they came. But we'd spent two years, and so I was in the middle of my residency, and did not have to go back to active duty.

You did your internship then at Shoemaker. You were talking a little bit earlier about the crowded conditions at the time — what was it, about thirty-six hundred patients?

Yes, thirty-six hundred patients in the hospital. We were pretty busy as interns. We had — I think there were twenty-four, twenty-six interns for thirty-six hundred patients. Of course, each ward had their medical officer, but we kept going. During my internship we used to have to stand the duty at night. I think it was port and starboard; you stood one night, and then you could go home the next night, and then you were on the following night. So that you worked there from eight o'clock one morning through the night until six o'clock the next day. But you had a room there; you could sleep.

We'd get these patients in during the last part of the war; the navy and army got real good at transporting these injured people back. We would have them in the hospital there in Shoemaker from Okinawa maybe

in forty-eight hours after they were injured. They'd fly them right back. So we did have a bit of practice. But the day that I remember was V-J Day, because they had such a big celebration in San Francisco that a lot of our navy personnel were injured, and so they transported them to Treasure Island Hospital. They sent all the patients from Treasure Island Hospital to Shoemaker with not one bit of paperwork. Here were six interns on duty that night, and we had to take care of I don't know how many — one hundred and fifty patients. [laughter] And it was just getting the history and getting them in the right wards. Anyway, I think thirty patients I saw in four hours that night. [laughter] I will never forget that day. I guess, you know, it was a wild time down there. A lot of auto accidents and fights and whatnot.

Did that spark or help to spark your interest in surgery, the war wounds?

I don't think so. I think the interest in surgery came more from seeing the emergencies that arose. It was easier in small places. In general surgery I could do the most good.

Did you always intend to come back to Elko?

I suppose I did. [laughter] When I left and went to college, gee, I thought that was the finest place in the world, down there in southern California. The home town was all right, but I thought — I'd like to see the world and get out in large cities. But the longer I was away from Nevada, the more sure I was that I would come back. Driving around fixed my desire to come home.

You said you did a preceptorship under Dr. George Collett? Could you explain that?

Well, in those days most surgical residencies were just three years, but for the American Board of Surgery, you had to have five years of training. So they would give you this formal training in a residency of three years and then let you go on out, and all your work was supervised by a board surgeon. I was his assistant all the time. [laughter] And so he knew what I was doing, and then at the end of that period, he would certify that I had this experience in surgery, and that was what a preceptor was. That allowed me to take the board examinations.

This was a small area. Where were you drawing from? What type of surgery were you practicing? And did you have a great deal of variety?

Yes, we did. First of all, in those days it wasn't a matter of calling an airplane and have them in Salt Lake or Reno in several hours. You took care of the emergencies and did what you could. I had an area that drew from essentially all northeastern Nevada, I would say from Battle Mountain here and from Wendover here and everything north to Idaho and not from Ely, but this side of Ely. So we had a fairly big area, and when I started with the clinic there were . . . Dr. Collett was the surgeon and I was a surgeon; that was all in surgery. But there was Dr. Moren and Dr. Hadfield who were general practitioners. Dr. Read was an internist. Dr. Secor and my father, they were general doctors here.

So your dad was still in practice?

Yes, my dad was. But he was partially retired; he wasn't part of the clinic when I joined. They had an office down there, and he'd see his patients. He didn't work real hard the last few years.

With the ranching and the mining that was taking place in this area, do you think that made the medicine different?

Oh, yes, yes, I do. Not so much the mining. In those days there wasn't very much in the way of mining. But the three things here I think made practice different, particularly in practicing surgery, was the ranching and perhaps predominantly the highway. U.S. 40 went through here. It was a two-lane highway, and it was a real dangerous highway at those times. I can remember in the 1950s when there would be — oh, yeah, more people injured in Elko County than in any other county in the state. We had thirty, forty deaths from highway accidents. And this really put a lot of pressure on us. The railroads . . . we had a certain number of railroad accidents. A certain amount of injuries from the ranchers; people who were around heavy equipment and horses in ranching would be injured. There was quite a variety of injuries we had that kept us real busy. So the railroad injuries and the highway and the ranchers were the things that really kept practice of surgery going here.

Did you do emergencies, trauma medicine?

I would say that was the most of my practice. And some severe trauma! Oh, my goodness. I don't know, it must have been in the early 1960s when they first came out with a polio vaccine. We mobilized all the doctors in Elko, and were going to cover the whole county. You go here and you go there. All we did was give them a tablet to take. We'd put a little drop on the sugar and let the kids eat it.

It was on a Sunday, and we were on our way to Wells. On the way up we came across this accident. Eight people were killed, I think it was, and a number injured. Well, it was the

worst highway accident I had seen — it was things like that which kept you busy with the highway work.

You had the facilities to handle this?

Well, yes. In today's milieu it wouldn't be very much in the way of facilities, but we had to do with what we had. There was nobody else to take care of them. Consequently, I did a bit of orthopedic surgery. Of course, general and abdominal surgery and some neurological surgery and urological and plastic surgery, amputated thumbs and things like that. You had to do a certain amount of burns and grafting. We took care of them all here.

Just as an example there is a condition with a head injury where you get extradural hematomas, you know. They get a clot from the middle meningeal artery rupturing in the temporal bone and bleeding. It became a real immediate emergency in those days, and the neurosurgeons in San Francisco really drilled this into us. These had to be operated within four hours, or they were dead. Around here there was no chance of getting a neurosurgeon, so we did a number of those decompressed extradural hematomas. Now they pump them full of corticoid steroids and send them off. [laughter] But they can get them to a hospital in Salt Lake City in an hour or two, but you couldn't in those days. I think that was one of the most gratifying parts of my practice was seeing you could have some results in doing these things.

And that's what you mentioned earlier — you were looking for something where you could see the immediate results?

Yes, yes.

Had your residency really prepared you for the sort of things that you were seeing?

Well, you know, it had. It really had, because when I got out of internship and went to get a residency, it was tough. All the doctors from the services were coming back and wanted residencies. For every residency available there were ten people applying for them. So they started this residency down in San Francisco. It was the hospital where all the Western Pacific employees were treated in San Francisco. The chief surgeon of the Western Pacific Railroad, he knew what our problems were and he was the one who really directed the training down there. They tried to make ours a very general surgical residency. And I think they did a very good job on it. We weren't training in the real intense surgical procedures, but general coverage was what they were after.

What about going into practice in the Elko Clinic? Mrs. Patterson's book, Sagebrush Doctors, talks of the formation of the Elko Clinic and that your father was one of the guiding forces behind it.

He was, but he actually was not a partner of the clinic. The office dates back way to when my uncle, Charles Hood, came in the 1890s. My father came out and practiced with him, and when my uncle retired, my father got a partner. I think it was Dr. West who first came there and practiced with him for a while. Then he went to Reno to practice, and Dr. Secor came to practice with my father and Dr. Roantree. For a number of years then, it was Hood, Roantree and Secor. Then in 1948, why, the young fellows were coming back, and they said, "Let's form a clinical group," and that's what started it. The people in that were the ones that formed the Elko Clinic.

Why did they want to form a clinical group like that? What was the reasoning behind it?

Well, they thought in an area isolated like this with a number of men, one could concentrate on one specialty and the second on another. We could generally give better service by practicing together and then you are not always fighting. You could pool your resources and by that means give better service. Dr. Moren was one of the founders of the Elko Clinic.

When did you retire?

It's been so long now. I think it was about 1982 or 1984 when I retired. I retired because the emergency room was getting too much for me. In those days you took your calls in surgery at the emergency room, and there were usually three of us covering the emergency. Every third night you took over surgery that came in. This was not big surgery all the time, but people would get drunk and get in fights and get lacerations, and the surgeon had to go out and suture him up. It got to be that we were up two or three times a night. It got kind of bad to be up there working all night and then to try to practice surgery, operate the next day and see patients in the afternoon. It got pretty stressful for me, plus the fact I was getting older [laughter] and developed a tremor. I have a tremor that's inherited. I didn't think that was good for a surgeon. [laughter] They could have changed that emergency room setup but some of the doctors said, "No. It brings in too much money," so they weren't going to get full coverage. And as soon as I quit, full coverage came. [laughter] But that was all right.

So when you retired, you had been in practice a long time, more than thirty years? Can you

comment about the changes that you noticed or experienced or witnessed?

Oh, I've got lots of comments on that. [laughter] Especially when it comes to the Board of Medical Examiners. You know when — it wasn't long after I'd started practice in 1950-51 — this probably is an exaggerated statement, but I think I knew every doctor in the state of Nevada. There may have been a few in Las Vegas I didn't know, but I was acquainted with everybody. Now I don't even know all the doctors that come in and cover the emergency room in Elko. What a change that has been!

When I started, the Elko Clinic got a fee from Elko County to take care of the indigents. For a hundred and fifty dollars we took care of all the people who could not pay professional fees. One hundred and fifty dollars a month. And we did everything. The internists took care of the heart; we took care of the surgery, nailing hips, broken bones and all. I dare say that we more than earned that one hundred and fifty dollars. [laughter]

In those days there was a poor farm out here that the county had which took care of all the old men. They had thirty or forty men out there in this old brick building. It used to be a hotel, and they had a swimming pool. There were some hot springs, and they had a garden and hogs and cattle that they raised. They really took care of themselves out there.

The County Hospital — it's not the one they have now; there's several new ones since then — was up here, and it was run pretty much on a string compared to now. The catheters they would use were rubber. The nurses had to boil the catheters, all the linen was washed, and everything was done by hand. The nurses there worked like dogs to take care of all this. They did the best they

could. The needles were always re-sterilized. And we never, even later on, thought of asking for new equipment. Now, gee whiz, they think nothing of spending ten or twenty thousand dollars on a new piece of equipment. [laughter] And that's just been since I quit. We got by on the best we could.

But there have been a lot of changes, plus the fact in those days we were forced to take care of a lot more injuries and conditions that perhaps could have been taken care of better elsewhere with more help and more efficiently trained men. But you did what you could. I think if you look further back, at the 1910s and 1920s, my father's era, why, we had it good compared to them. As a matter of fact, I was thinking of my father telling me when I started practicing, "You know, I really kind of feel sorry for you young men starting out, because we had the best years in medicine. It's all done now, they've got all these new medicines, and there's nothing more to look forward to." [laughter] They hadn't even scratched the surface then. The way we started, things went along pretty good.

I think it was more fun practicing medicine when we didn't have very much money and we were taking care of a lot of the indigent people who couldn't afford medical care. I remember the professors at medical school saying, "When you go out and practice, don't expect to get paid for all this, because you've been taught now that it's up to you to give a little something back. You should treat some of these people." But the government got in it, and that kind of ruined all that philosophy, because they said, "Look, you can't treat anybody free, because we're going to pay you the least fee you charge for that procedure. Well, that's what we'll pay you." So if you took out somebody's appendix and didn't charge them, well, you got paid nothing

when the government came in. I really did have a lot more fun before the government was involved. I didn't have any money, but it was fun practicing. [laughter]

You mentioned the poor farm and the men that took care of themselves. Where did they come from?

Well, they were old characters around here. There were a lot of cowboys and ranchers and working people. I don't know what happened to women in those days. There were always the men that didn't have any place to go.

No poor farm for the women?

No. And I think that's one reason why the government said, "Look, you can't have that poor farm." Well, of course, it was inadequate, and they said you have to have nursing homes and that sort of thing. I don't know. I tell you what I really think, families would take care of the women. They always had a daughter or a son or a daughter-in-law, somebody that would take care of them. But the old guys, they got to be old reprobates, and they were quite the characters out there. Every once in a while one of them would get loose and go downtown and come back three-sheets to the wind. [laughter]

You mentioned some of the emergency care that you had for people who were drunk and disorderly and a little bit rowdy. Do you think that that was part of life in Elko, then?

Oh, yes. I surely did. Well, it was a western town, was filled with cowboys and that was just their life, coming in and having a good time at the bars. Of course, some of them

became alcoholics, a good percentage. It was just part of the milieu, I think.

One of the functions of the Board of Medical Examiners is to oversee physicians as far as making sure that they're still practicing good medicine and that they're living moral lives. One of the standard charges is that of unprofessional behavior. They have had to deal with physicians who were involved in alcohol abuse or drug abuse. Now they send them off to get treatment for that. What about when you were practicing medicine and when your dad was practicing medicine? Is it something you were aware of?

I was just thinking about when my dad practiced medicine. I suppose it was. I was never aware of any of his associates having that trouble, but in my lifetime we've had our share of difficulties here. One of the toughest things we had to do as a hospital board was to patrol our own individuals or to control our own practicing physicians here. I don't think the Board of Medical Examiners in those days did much of that. It was kind of up to the Elko County Medical Society to do it. I think most of the medical societies in the state had the same problem.

Without using any names, I can tell you about one young man we had who came in to practice surgery — he wasn't with our group — that was an alcoholic. He would bring a patient in to do some procedure, maybe a minor procedure, and the nurses up at the hospital noted that he was drunk. The only thing they could do was call the chief of surgery. Well, we took our turns of being chief of surgery and one of us had to go up there and say, "You can't do this now in your condition." That was always a very tough job, as you can imagine, to tell him. He felt we were one of his competitors telling him that he couldn't do that surgery. But you had to do that.

That was not a real isolated circumstance. We had another one who wasn't living in Elko, but in the county, and he used to do abortions, and it was known that he did abortions. Of course, in those days that was a crime. You couldn't do those. This chap would go ahead and do them, and he wanted to get on the hospital staff, but we didn't want him because we knew that he was doing abortions.

We had another man that was a surgeon, a prominent surgeon, I'd say, from southern California. He used to come in and do operations. He wasn't a very good surgeon, and he would do major procedures and then go out and wouldn't be seen for three or four days. Then it would fall upon some of the rest of us to try to take care of his patients. Nowadays I think the complaint would be made to the Board about a surgeon who would do this.

But then you just tried to take care of it?

Well, we did; we talked to him and all, but that was just out of sympathy, you know, for the patient. Somebody had to write the orders. We did it, although we didn't like to do it.

Do you know why he was he casual about it?

Well he was getting to be a pretty old man but I don't know why. He was associated with another man in town. He would go out to his ranch and then leave the care of a patient for this man who was a chronic alcoholic. Once in a while he'd go out on a binge and there was nobody to take care of his patients. It was something we worried about constantly.

Do you think the public was aware of it? Or was it something that just the medical staff was aware of?

I'm sure that the public was aware of some of it. But a lot of these were things that just the medical staff knew. We tried to keep it that way. I don't know; maybe it was wrong to do that. Maybe we should just have let the chips fall where they may. But we didn't think that was quite right.

A Dr. Walker wrote a history of medicine in Nevada. It was actually published in the 1940s. One of the things that he stressed was the dignity of the profession. Do you think that emphasis has changed over the years?

I surely do. I have a letter — this is a demonstration of this — that a lady from Arizona sent me. It was one that my uncle, William Henry Hood, had written when he was practicing in Battle Mountain to a lady who was inquiring about the health of her father. He sat down and wrote in long hand a sympathetic letter telling her all about it. I couldn't see any doctor doing that now. But sometimes that was all they could do in those days. They didn't have all the fancy equipment and drugs and means of curing diseases. A lot of it was just being sympathetic, explaining and all that this is what the situation is. I was so proud of that letter that my uncle wrote. I'll show you that.

And she sent it on to you to keep?

Well, yes, she did, because she knew I was the only Hood left, and she sent it on here with the original and then a typed copy of it. I think the original and the copy is up in the museum, but I kept a copy of it. He explained that this was congestive heart failure or something similar. He was on the train going back to Michigan at the time — and he sat down and wrote this letter. I thought, "What a difference practicing medicine in those days," but, you

see, the poor fellow couldn't really do very much for his patient but sit down and explain to relatives.

One of the concerns that I've heard expressed, and this was in the middle of the century, that with the new medical techniques — even just for development of X rays — that physicians weren't as observant as they had been.

I think that's right. And not only weren't they as observant, they weren't as willing to sit down and listen. I'm sure that I was, to a certain extent, that way. The old-timers — there was something about them. They were always dressed well and dignified. And a doctor was held somewhat in respect in his community. It's not that way anymore, but that's the way I've seen medicine just change. When I first started here in 1950s, I'd go up to the hospital and those nurses were all dressed up in white uniforms and white hats, and everything crisp and nice. And the same down at the offices. Nowadays the nurses — they just come in regular clothes. Doctors never wear a tie. My dad wouldn't make a house call without stopping in the middle of the night, get up and put on his suit and tie and a coat to make the house call. Because that was their position and they felt they should do it.

I remember when I was — I guess I was in high school, and there'd been an accident on the railroad at Silver Zone, this side of Wendover. One engine was pulling a freight train up this grade, and the other was pushing it. Something went wrong with the one pushing, and that thing blew up. Blew up right into a caboose — that steam hit that caboose and flattened things out, injured all these men and killed several of them. But I can remember that phone call. That was when I decided, at that time, I didn't know whether to go into medicine or not. [laughter] But I

remember my dad getting up, answering the phone, getting dressed up in a suit and coat, and going down here to be taken up on the train to treat them up there at Wendover. It was eighty or ninety miles up there, you know. But he would never make a house call without a suit. Some of the doctors I don't think even have a coat. [laughter]

By the time you were practicing medicine, were most of the people transported to the hospital or the clinic, or did you have to perform emergency medicine on site?

Well, no. When I first started we used to make a few house calls, but, really, you got so you couldn't do much out there. Sometimes I'd go out and make a house call and call the ambulance and put them in the ambulance and take them up to the hospital. But, by and large, things had changed a bit.

No more surgery on the kitchen table?

No, none of that. I don't think I would not be up to that. [laughter] I guess my dad used to. Let's see — I just can't remember of ever doing any surgery outside of the clinic or the hospital, other than just rendering first aid. But I have nothing to tell about my dad's experiences, like going out and operating on the kitchen table. I'd be awfully afraid of that now; we had enough infections with sterile procedures and all. So I would think you'd be opening yourself up to malpractice if you got an infection. But in those days it was different.

Do you see a certain loss of independence? You talked earlier about the government coming in, and you couldn't treat people free anymore.

Yes, that's right. There has been; it's been restricted more, especially with malpractice

suits now. Although I noticed that it mostly was in the orthopedics. We used to do all the orthopedics. Now, if it doesn't come out right, why, then you are in trouble because you weren't trained in orthopedics. So you became much more restricted as time went on, I'm sure. And that's probably right.

Your dad was a general practitioner. Do you think that day has passed?

Well, for a practice where they do surgery and deliveries and all this, I think the general practitioner has now become the family practitioner. They can talk to these people and see what they need and take care of the minor things and refer the others on. In the past, there wasn't anybody to refer them to.

So it had become more specialized by the time you started practicing?

Yes. I think World War II was what brought that on. I think it was the development of medicine. You know, during each war, why, practice of surgery has advanced so much because of all the trauma. And, too, in the past, all the infections — in the Civil War, more people died from infections than they did from wounds. But war always seems to advance medicine. I always thought I was real fortunate to see the development of penicillin. This is what my dad meant when he said, "We've seen all the advances when they got penicillin." But they haven't. Of course, nowadays we don't know if it was so good or not. [laughter]

But I remember when I was a student, medical student back in St. Louis, going to St. Louis City Hospital and making rounds. One of the doctors had a patient with this kind of hand infection; cut his hand and it got infected. I guess it was palmar's space

infection. It was all swollen up. This is before they had penicillin; the army and navy had, it but they couldn't get any for civilian use. But if we had had penicillin, maybe we could have saved this fellow's life, but he was going to die and he did from infection. That's the way things were in those days.

What would they have done for infections pre-penicillin?

Well they had sulfa drugs, but mostly you just drained. They used the old surgical procedures of incising and draining and leaving the wound open, and all the drainage took the infection out.

I would like to hear a little about the doctors that you practiced with. You mentioned Dr. Roantree, and he, of course, was a member of the Board. Also Dr. Collett and Dr. Moren. Maybe you could tell me a little about those men, any anecdotes that you have?

I would be delighted to. Dr. Roantree I knew as a very young child because he was my uncle by marriage. His home was in Wisconsin, and he went to medical school in St. Louis at Washington University. He had some surgical training in Salt Lake City. He was a man that was certainly loved by his patients around here. He did most of the surgery here in town during the 1920s and early 1930s and even into the 1940s. He had one child who became a doctor and taught bacteriology at Stanford University Medical School.

Dr. Roantree had somewhat of a sad life, because his wife was ill for the last ten years, maybe fifteen years, with an illness. I don't know exactly what it was, but she went gradually downhill and died several years before he did.

But he was associated with most all of his practice here with my father; they were always Hood, Roantree and Secor. Dr. Secor was also an older doctor here. My experience with practicing with Dr. Roantree occurred only during the late 1940s and early 1950s. He was a very excellent surgeon, I thought, and one who was really happy to teach us. I enjoyed practicing with him in the little time that I did. He was one of the first doctors in this area to join the American College of Surgeons. He was well thought of in that organization. He had a lot of good friends that were rather famous surgeons, such as Dr. Cole, who was at the University of Illinois; and a neurosurgeon, Dr. Sax, in St. Louis; and the surgeon in New Orleans, Ochsner. So he was quite well known among surgical circles.

One of the stories I know shows how times have changed. Of course, Elko Hospital, I guess from the time they started, was accepted by the American College of Surgeons. They used to grade the hospitals rather than the American Hospital Association. It was all up to American College of Surgeons to be approved. I didn't know this, but Dr. Collett, the older Dr. Collett, told me about this. They would say, "There's going to be an inspection team come by from the American College of Surgeons, and so be ready to have the hospital shown." So Dr. Roantree knew most of them, and he would meet them. He would take them up to the hospital and show them around a little bit; then they'd go downtown, and he'd take them to dinner at night. They were all approved, you know. [laughter] But times have changed since then. And, of course, he was on the Board of Medical Examiners; I'm not sure if he wasn't the president of the Board of Medical Examiners when I took my boards in 1947. I think it was 1946 or 1947.

I'd only taken the first part of the national board, so I had to come and take the state

board. It was quite interesting at that time. There were, oh, I think eleven of us. But we had to spend two days. We came to Reno, and they gave us a written test, and it was kind of tough. I remember they gave this on various things, and the one I had trouble with was with dermatology. I had had very little dermatology, and they had some real tough questions on that. [laughter] Then they talked to you, too, and, as I say, he was my uncle and I had no trouble. But, anyway, I got my license at that time. Dr. Roantree, after his wife died, he was kind of at loose ends, and he had a coronary and died in the 1950s.

Now, let's see — Dr. Moren; I'm sure you have most of his background already. But he was always a very congenial man to practice with. He was very concerned about his patients. I know when they didn't do well, he would feel there was something he did wrong or something he hadn't seen. And he was a very busy man, mainly doing obstetrics. We had no obstetricians here in those days, so he delivered thousands of children. As a matter of fact, here about twenty years ago they had a big party honoring him, and he had, at that time, delivered something like thirty-five hundred babies during his life. He was another very well-liked physician. It was a lot of fun to practice with Dr. Moren.

I think I have told you a little bit about my father. You see, really when I started my practice of surgery here was 1951, and he was only doing a little bit of work then. The Elko Clinic was on Idaho Street, and there were maybe four or five or six of us who were practicing then. He would come down in the afternoon at two o'clock and see some of his old friends, and once in a while he'd work. But he really didn't do much practicing at that time. He'd been real busy during his life.

In 1954 they had the Nevada State Medical Association meeting here. They

honored him at that time as being the first fifty-year member of the Nevada State Medical Association. He had a plaque, and a man by the name of Jack Myles, I think it was, wrote quite a bit on him. But he did have a great life, and I think he died in 1958.

Dr. Secor was an older physician and had a rather interesting life here. He first came out west to Nevada to practice in Cherry Creek. You know where Cherry Creek is? It's down north of Ely, an old mining settlement there. It was where Pat Nixon was born. Dr. Secor practiced there, and if I recall, Cherry Creek was on the downhill side then, and so he came up and started practicing in Tuscarora. He practiced there until the World War I came, and then he joined the army. He came back and went in with Dr. Roantree and my father as a general practitioner.

The interesting thing about Dr. Secor, he never took a note. He never wrote a thing. But he had a great memory, and he could remember what was wrong with people and what he'd done. He never had a written note. It was kind of tough if you got patients after Dr. Secor had seen them, because there was no written history. [laughter] But I think he's the only man that I've ever known that never kept notes. And, of course, you couldn't do that today.

He was quite a historian. He was interested in the old immigrant trails through here, and he went out along onto the salt flats and collected things from the old Donner party that had gone across there. He was a very jolly, interesting man to talk to. During his later years he slowed down on his practice, although he did continue, but he gave all the anesthetics for Dr. Roantree and Dr. George Collett and for a while for Hugh Collett and me. It was always drop ether; he was trained in the old times. And that was the anesthetic we had, general anesthetic, drop ether. It was

all we had in those days, and we were lucky to get that. He was so good at that, and I don't recall ever having any severe problems when Dr. Secor was up there giving drop ether.

He died pretty close to 1957, as I recall; I'm not sure. Some of the experiences — one stands out quite visibly in my mind. We used to get all sorts of patients in here, you know. We'd have to take care of any emergency that came in. One day we had this one old hobo who had appendicitis. Dr. Secor was up there giving ether, and he kept leaning over and was putting ether on the floor. I said, "What's the matter? What's going on?"

He said, "Those lice are dropping off this guy, and they're getting on the floor." And he was pouring ether on the floor. [laughter]

He put ether on the lice?

On the lice; they were stone dead, yes. [laughter] Every morning he was such a jolly fellow; he would always have some tale to tell about and laugh about it. He had a real good belly laugh. Dr. Moren always appreciated that, too. We had a lot of fun with Dr. Secor. During the last year or year and a half, Dr. Secor quit his practice and went into a severe depression. Never saw him; he just stayed right in his house and never came out before he died. He lived there on Juniper Street, between Fourth and Fifth. Had a little house there. Now people would say it was a very small, modest little house. They never had any children. Both his wife and his mother outlived him; his mother I think died just when she was in her hundreds.

You mentioned that he practiced in Cherry Creek, then Tuscarora, and in Elko. Do you think it was easier to move a practice then? Was it more common?

Oh, yes, yes. I think it was. You know young doctors would graduate back east and they would come out here. You didn't have much investment in equipment, and I don't think they ever had secretaries or nurses that worked for them much, and they just set up. It was very easy. That was the way they'd come to these mining towns. As the towns went down, they'd move on.

There was another chap who was a partner of my father, though I never knew him. Dr. West came out here and practiced in Edgemont, which was a little mining town up near one of the branches of the Owyhee River. It was up on the other side of the Bull Run Mountains and quite close to Idaho. There a little town up the canyon there; I don't know how many people. The life of the town wasn't very long, and then he moved down and practiced with my father for a number of years, and then moved to Reno after the war.

Dr. George Collett, who was my mentor when I started practicing surgery, came out here I think shortly after the World War II. He had quite a surgical practice in Indiana, and I think it got a little too much for him, so he came out west looking for a place and landed in Elko. He liked it and started practice here. He was an older man and an excellent surgeon and quite a philosopher. He was very instrumental in starting the Elko Clinic with Dr. Moren and several others. When I first started my surgical practice here, he was the only one I could turn to for help, and he was very kind and certainly helped to train me.

You know, he was probably in his sixties, maybe late fifties, when I came. And he was very generous in splitting the call with me. I would take certain call one night and he the other. He would always take his share and not overload me.

He was always looking forward to his son, Hugh, who was the same age as I was, coming

back and starting practice with him. Well, through Dr. Collett, I got to know Hugh. As a matter of fact, we both had our surgical residencies at St. Joseph's Hospital. But I was a year or two ahead of Hugh, and I got out and came up and practiced with Dr. Collett. Hugh was going to come in 1954, in June of 1954, and Dr. Collett was always looking forward to it; that would be great. Of course, we all were looking forward to it. In February of 1954 he had a coronary and died here. So he never got to realize practicing with his son. One night he went to bed and had this heart attack.

What is the impact of something like that on a town this small?

Well, I don't know about on the town, but it was sure a big impact on his medical colleagues. He was really the senior man and kind of guided things, and we really felt almost at loose ends, and especially since I was left as the only surgeon in town. It was a terrific impact on us. I don't think that perhaps the impact on the general population was too much, but it surely was on his medical colleagues.

Dr. Hadfield practiced here, a good friend of Les Moren's. He probably practiced two or three years; then it got too much for him, the general practice and all the calls and everything. He quit and took a residency in anesthesiology and practiced anesthesiology in Washington State from that time on.

There were a number of doctors that practiced here for a while. They were young ones that came and left, but none of them were here very long. They came here to practice because they had some time before they started something else. They wanted to fill in their time, and we were always happy to take doctors for a short while to help us.

There was one young fellow that came and settled down and was going to practice here, in the late 1950s, I guess. I've forgotten his name, but he came and practiced here, but he always was gone. He would put his wife on the train, and then he'd be out with some gal. He was operated on by a neurosurgeon up in Salt Lake City for a supposed brain tumor, but I don't think it turned out to be anything. He wasn't too steady; you couldn't count on him.

You mentioned when Dr. Collett died that you felt a little at a loose ends, the only surgeon in town. For most of your practice, were you the only surgeon in town?

Oh, no. No, because, you see, that was in February; in June his son, Hugh Collett, finished his residency and came up and joined us. That's why I kept going, because I knew I would have some help.

Is it easier to have someone around?

Oh, it surely is. For several reasons, in surgery it is sure nice to have another surgeon. One is you can change call, so you aren't up every night. In a town like this, if you took all the surgical calls, you were up practically every night. Number two you have somebody to discuss cases with. In the type of surgery we were doing, it sure helped to have an assistant at the surgery that was well trained and could give you some advice. So it was a great help to have someone else around. After Hugh Collett came, we kept pretty darned busy, the two of us.

We were looking around for surgeons and got a Dr. Matern, and he was a well-trained man. I think Dr. Matern was from Cornell. But he was a very religious man and became a missionary after he practiced with us for a number of years. He went over to Tibet, Kathmandu, where he practiced and did a

lot of surgery there. He gave a lot of his life to that area. He became ill and he's still living, but I think he's down in the San Diego area. He and Hugh and I practiced for ten years or so. After he left there was nobody else until 1970 or so. Dr. Owen, Howard Owen, who Hugh had known, was a surgeon; he came, and so there were three of us again. Howard Owen retired when I did, and then Dr. Hugh Collett two or three years after that.

It is amazing the number of very prominent men we got through here. There was one when my father was practicing — maybe it was before he came here — a doctor up in Tuscarora when it was going, by the name of Dr. Huntington. After he practiced there for a while, he went down to San Francisco and he became the leading surgeon on the Pacific Coast. He was chief surgeon of Southern Pacific Railroad, he was head of surgery at the University of California, and he had his start up near Tuscarora.

Another later famous surgeon we had was a young man was practicing up at Owyhee for the Public Health Service. He was interested in surgery, so he used to come down, and Hugh and I would have him help on the surgery. He really appreciated that. But his name was Lower, Dick Lower, and Dick went on to get a surgical residency at Stanford. I suppose he's still practicing. He was chief of heart surgery at University of Virginia.

I think that's typical in small towns and in the medical profession: you get to know these people that are going up and come through. I knew one surgeon from the Los Angeles area; he used to ask us to help him on surgery. One I helped him with was Maureen O'Hara. She came up here to have him operate on her.

What do you think a small town, a small area like this, has to offer to a physician that a larger town doesn't?

Well, in the old days one thing you had — you really were a respected citizen in the community when you came. People looked up to you and were very kind to you, and you never had much trouble getting along with people. I don't know. Now I'm not sure. I hear people criticizing this doctor and that doctor. There isn't quite the respect that they used to have.

Why do you think that is?

Well, I suppose it's just the economics and medicine. And perhaps the type of individual now that's going into medicine, too. In those days you were well known to most of the people in town. Now you're a psychiatrist, or you're a radiologist. Specialization, I think, perhaps is one of the reasons. Economically I don't think there's any advantage going to a small town. I think you can make more money in the larger places.

I had a visit from an internist who used to practice with us up here in Elko, and he left maybe four years ago, five years ago, something like that, and went down to Las Vegas to practice. He said, "You know, when I was here, the government allowed me twenty-four dollars a call for seeing Medicare patients — twenty-four dollars a call. Immediately, when I got to Las Vegas, I was getting forty, forty-five dollars." I think probably you do better in a larger place.

The life-style is the one thing that the small town has to offer. I think you don't spend a lot of time in traffic, and you are close to the country, so that you can get out in it. There are a lot of opportunities in small towns, like being associated with the community itself. I found that most rewarding. There were all sorts of things that we needed here. We needed a golf course, and we needed a museum, and we needed a hospital, and we

needed an auditorium and convention center. During my lifetime I got involved in all of these things. I was president of the society that started the museum. I was on the board until last year. When we got the convention center and auditorium, why, I was chairman of the first one, but I tell you who had the most credit for that was Mrs. Moren, Dr. Moren's wife. She really did most of the work on it. We had a bond issue, and it was voted down; they weren't going to spend that money. But that made a lot of people mad because it was voted down, and so they said, "Well, we're going to start it again and get it next election." So they started. I dropped out, and Dr. Gallagher stepped out. We thought maybe it would do better without us being associated with it. Then they passed it, but I felt I had something to do with it, getting that in. But to see these things develop, it was very gratifying to live in a small town like this. The doctors here now I don't think are particularly interested in community affairs. They are more interested in just in the medical aspect.

You made a brief reference to the type of people coming into medicine changing. Can you elaborate on that? Do you think that motivations for going into medicine are changing?

Yes, I think it is a little bit. You know, when I started, I don't think most of us in my age went into medicine to become rich. We made a living. They always told me in medical school, "Don't worry about what you charge; you're going to make enough money." But during the past twenty years I would say, you know, when you look at all these statistics about who makes the most money, doctors and lawyers and professional men — I think that makes a difference in the reason people go into medicine. They say, "What can I do

for a living?" Well, you know doctors So I think there is a difference. Perhaps it didn't cost us much to go through medical school. Now it costs a whole bunch, [laughter] and maybe that's the reason that it is so important, the economics of it.

You mentioned you changed your mind a couple of times about wanting to be a doctor, a doctor in the navy. Why did you want to be a doctor?

Well, I suppose when I look back on the reason, part of it was my father was a doctor, and I looked up to him. I think that was the main reason, and after I got going and a little more mature, I could see that that was my best hope.

You have a group of Hoods, you mentioned what, six?

Yes, six. My father's oldest brother was a Charles Hood; he graduated from the University of Michigan Medical School, then went up to Spokane, Washington, and practiced up there. A year or two after that his next oldest brother, William Henry Hood, graduated from the University of Michigan Medical School and came out and practiced in Battle Mountain; he located there. So then my father was the next — he was quite a bit younger than the other two.

How many children were there in the family, do you know?

Well, let's see, I think there were five. They were farmers in Michigan, Adrian, Michigan. I've been back to the old farmhouse. You know, they were not very well to do and all. They were pretty poor. But, anyway, after my father got older, he went to Adrian College

and then to University of Michigan Medical School, and I think his brother up in Spokane by this time had moved down to Elko. I think it was about 1889. He needed help, and so he helped my father through medical school. Then my dad came out and joined him. When he arrived here, he had two bits in his pocket; twenty-five cents was all he had by the end of the trip. [laughter]

His first impression of Nevada was quite interesting. He came all the way on the train, and they'd stop almost everywhere, I guess, in those days. He crossed Utah and came into Nevada and was sitting in the chair car next to a man who was sleeping. The train came up and ground to a halt, and he was going to get out. And this guy next to him pulls his blind up and looks out and said (there was a station there), "D E E T H, death, and it looks like it." [laughter] That was Deeth, so he slammed the shade down.

So my father came out here and practiced. In the meanwhile, William Henry Hood — I guess things got a little slow in Battle Mountain, and he moved to Reno and set up his practice there. This was about 1900. He and his wife had two children. There was Arthur James the second. He was named after my father, who was Arthur James the first, but he was called Bart, Bart Hood. Dwight Hood was his younger brother who was born two or three years after he was, and they called him Dutch, Dutch Hood and Bart Hood.

Both of them became physicians. Bart went to Stanford University and graduated down there and came back and practiced in Reno. Dutch went to Washington University in St. Louis and came back to Reno and practiced. Dutch became an internist; for a long while he used to read all the EKGs out there at St. Mary's. And Bart did quite a bit of surgery; he was more of a surgeon. I think he divorced his first wife and then married

this divorcee from back east, who was quite well to do. They led quite a social life down there. Then she died, and he married again; they lived up there on California Avenue in Reno. Bart died, oh, it's been ten years, I guess. I think he had kidney cancer. He had two daughters; one was just a stepdaughter and then the other and a son. One of the daughters is dead now, but the other one is married to Frazier West, who was Dr. West's stepson, so it was kind of a mixed up family affair.

Dutch had a lot of pain, a very sad life. He was married and had a son. They had rather steep stairs down the basement, and he came home one day, and his wife had slipped and fallen; and when he got home, she was dead at the bottom of the stairs. This just really broke him up. And then if that wasn't bad enough, of course, his only son was killed. He was really interested in him, and he used to take him out hunting. One time they were down hunting in Fallon in the marshes and went through a fence. The boy was carrying a loaded shotgun, which went off and killed him. So he lost the both of them. And this was a sad thing. So then Dutch, he was, I think, a very well thought of internist down there, and he married a lady from Georgia. But then she got emphysema and died, and he married again. His last wife is still living down there. I go to see her once in a while.

Now that's five, isn't it? And I'm the sixth and the last one. [laughter]

And then Dr. Collett and his son following?

I think in the smaller towns there's more of a tendency for the children to become doctors and follow in their father's footsteps. You see it a lot more, I think, since we have a medical school in Nevada. I see all the time sons of doctors and daughters of doctors graduating from the medical school. Now, I

think that's wonderful. I think they ought to carry on the tradition and stay in the state.

Do you think that as a son of a doctor you had a better understanding of what you were getting into?

I don't know if I did right away, but I think later on I certainly did. When I was young, I wasn't too impressed with my father's knowledge and his philosophy that he tried to impart to me. But as I grew older, my father got smarter and smarter. [laughter] And he was really a brilliant man.

There are some issues that the Board has dealt with over the years. One of the criticisms of alternative medical care is that some practitioners don't have the basic science grounding that regular medical doctors have. You mentioned that a number of osteopaths have practiced here. Osteopaths are often linked to chiropractic because of the emphasis on manipulation. What do you think about that?

Well, now I may have the wrong impression. In the old days that was right. They were halfway between M.D.'s and chiropractors, I thought. I think during the last twenty or thirty years things have changed. From what I know, they have pretty well discarded the old manipulations. And osteopaths have really followed down more the course of the medical training that we have in the medical schools. The reason I think they have flourished so well is that there are a number of people that couldn't get into medical schools and wanted to go into it and were accepted by the osteopathic schools.

As I understand it, California licenses them as M.D.'s. Now, maybe I'm wrong on this, but a number of years ago they started giving M.D.'s to all, and I think now the

medical board of California licenses them all. But they are not real Class A medical schools, though it's my impression that the training of these people has been upgraded quite a bit. And there may be some that are not very good. I think those in California are pretty good. But, you know, some of the state universities have osteopathic schools now: Michigan State, Oklahoma State.

The reason I know about Oklahoma State is we had a very good friend who was very interested in medicine. He was in the legislature at the time they were forming a medical school here. He was one of the staunch supporters down there. I don't know, without his support, whether they would ever have had a medical school. He had a grandson that wanted to go to medical school in the worst way.

Who was this?

His name is Norman Glaser; he was senator from Elko County. His grandson wanted to go to medical school. He went to the University of Oklahoma, and he had good grades, but they weren't quite up to what they demanded. But he applied to a whole bunch of schools. I thought he was a very good candidate for a medical school, and so I wrote some letters for him, and, of course, their one hope was getting into the University of Nevada. And the dean wanted to get him in. [laughter] But he couldn't do it. He didn't have quite the grades. They suggested that he come on down to Reno and work there a little in research or something like that, and then he'd get in next year. That sounded very attractive to me. That's how my son-in-law got through in a medical school in Texas. But he wanted to get going real fast, so he finally ended up going to the School of Osteopathy at Tulsa, which is Oklahoma State University.

You've got to keep up the quality of the men and women entering medical school. That's all there is to it. And that's quite a story in itself. You know, now we've got people that are really hammering at the medical school about getting minorities of various kinds, and they're not having enough minorities, and yet you've got to lower the standards to let them in. And this doesn't seem quite right to me. But that goes on.

Do you think it would affect the standard of practicing medicine?

I think if it goes too far, yes; I think it very definitely would. There are minority students that are just great. I mean they're real good. We have a black doctor who is very excellent here. I think if they can keep up the standards, they ought to. But to lower the standards to allow just minorities to creep in, I don't think it's right. I think we ought to keep our standards high.

What about acupuncture as alternative medicine?

I don't know. [laughter] I remember when there was quite a fuss, but I must admit, I don't know. I know that in the past there were a lot of herbalists and Oriental doctors throughout the West. It was kind of a history in southern Idaho that a lot of people went to Chinese doctors. They're a different practice of medicine, and I just can't condemn these particularly, because I don't know enough about them. I don't know that in those old days, in the days when they were pioneering this country, if there was much difference in the results. Most of the people got well, anyway. But I think in this modern day and age these people ought to be allowed to have the finest medical care, real professional care.

So you think the non-traditional medicine is OK? Should we regulate it rigidly?

I think it should be, yes, nowadays. In the old days I don't think so, but I think now if somebody has a cancer, and they keep treating them with herbs or acupuncture, and by the time they really find out about it, it's gone too far. I think it should be regulated, yes. Acupuncture, I don't know. The main thing is the relief of pain. I just don't know enough about it. "Oh, boy, it surely relieved my pain!" I can't see why it should, but it did. [laughter]

What about Continuing Medical Education?

Well, I differ from most all on that. I think mandatory Continuing Medical Education is a good thing. Granted, it's great if practitioners will take off on their own and get this. But having been in practice myself, I know time goes by awfully fast, and I think to have a little nudge from the state board is a good thing. The time is going fast, and without further training, you lose out on a lot on of your abilities and your knowledge.

So I'm not strictly against it. I think it ought to be pretty liberal. Maybe make it a two-year period, something where a man could go out and spend a month or so taking a course. Of course, when we started the Elko Clinic, we felt it was very important that our members went out and got continuing education. We set up a system where you got paid for going; the clinic would pay for the tuition that you have in courses and for your trip there. You know, it was always a very welcome thing, and I think it helped. We also said when we started that every three years you are supposed to get a three-month sabbatical. Well, [laughter] that didn't work out so good. [laughter] I think Dr. Read took a three-month sabbatical, and he was the

only one in the group that ever got that. We just couldn't afford the time off. But I believe that it's a very wise thing. Well, that's my own opinion. I know that I've heard the arguments against it. You can choose, and doctors ought to be enough motivated to go off and get it on their own. But having practiced, I know that it's easy enough to let that slip by.

One of the developments in medical practice is the existence of physician's assistants. This is something that the Board supervises. How do you feel about this development in medicine?

Well, I can see why it developed. You know, particularly in these small communities doctors were overworked, and they needed help and could get no relief at all. To get somebody that's moderately well trained to come in and give them some relief was a very appealing thing. I think that the Board should control this quite rigidly, because I can see that it could be overdone. But I think as long as it's controlled by the Board and by the physicians who use it, that it's fine.

I would say the same thing about the nurse practitioners. But there comes a time in a town such as this like — the poor guys who have to do obstetrics are just overwhelmed with the work, and it's really a great help to have a nurse's assistant or physician's assistant who can help with these matters. It helps patients in smaller towns to get into the medical system by seeing a physician's assistant. I think there's merit in it, but at the same time I think it should be very closely controlled.

What about midwives?

The same goes for midwives. There are two here in town that help the obstetricians. They will do deliveries, but they're under the

supervision of a physician. You know, you can get into a lot of trouble awfully quickly. And to have back up, well, that's the main thing — someone they can call in for help.

What about home delivery?

Well, of course, sometimes there's no other way. [laughter] But in this day and age I think it's better to have deliveries done in adequate surroundings, medical care surroundings. I wouldn't want a daughter or a wife of mine to be delivered at home. I know there's a lot to say for it, and they can get some of the hospital surroundings and more like home deliveries, but that's my feeling.

We talked a little about the osteopaths — what about homeopaths and naturopaths?

Well, homeopaths and naturopaths — I'd put them more in the class of chiropractors. And I think we are better off without them. Well, here again I think their treatments are ineffective. I think that they needed some good diagnosticians, but I don't think their diagnostics are too good. And I think they prolong a treatment of conditions that really require good medical care. That's my feelings. [laughter]

What do you think has been — if you could contemplate one — the most significant change in medicine which you have observed over the last forty years?

Oh, that's a tough one. I've seen a lot.

Is there one change or a series?

I think there are a lot; I don't think there is one that stands out. One: government control of medicine. When I started practicing, there

was very little — I've often thought how ideal it was practicing back in those days. And two: the malpractice situation that occurs now. We've got so many people just waiting to jump on any little thing. It's a real, real worry for doctors. Three: of course, is the tremendous increase in intensive care and scientific care and surgical procedures that greatly increases the expense of medical care. Like getting kidney transplants. There's no doubt it certainly has improved medical care and the longevity of people, but it has contributed to the exploding cost of medicine. I think those are the three areas where there's been the biggest change. After that, why, you can take — perhaps the diminishing respect that doctors have had in medical care. Even though the care is improved so much, the public's opinion has declined.

Why do you think?

I don't know. I think it is because there's been an increased expectation from the public about results. When I started practicing, there were doctors that were practicing who were really on the edge — they weren't giving the best care that I could see. And they never got into any trouble. Nowadays, if they don't get absolutely the best — boy, they are sued and criticized. I think that that's probably the most obvious, the increased expectations.

Would you do it again if you were twenty-one years old and starting out?

[laughter] Starting out? I probably would; yes, I would! [laughter]

THEODORE JACOBS, M.D.

Theodore Jacobs was born in 1930 in North Bergen, New Jersey. He graduated from Weehawken High School in 1946 and received a Bachelor of Science degree from Rutgers University in 1950. Interested in medicine from an early age, he continued that pursuit and was accepted at New York Medical College. He received his M.D. in 1955 and went on to a dual internship in internal medicine and pathology at Bellevue Hospital, Cornell Division, New York City, 1955-1956. He married Parvin Modaber during his internship in February, 1956. Dr. Modaber was completing an internship in obstetrics/gynecology and internal medicine at the University of California Hospital. Dr. Jacobs joined his wife in California, where both served residencies in internal medicine at the UC Hospital in San Francisco from 1956-59.

Their son and daughter were born during that period, and when the residencies were completed, Dr. Jacobs entered the air force and was assigned to Torrejon Air Base near Madrid, Spain. While there, he was able to explore his interest in bullfighting, as well as his medical career.

On the advice of a friend, who recognized the potential for growth in Las Vegas, Drs. Jacobs and Modaber moved to Las Vegas in 1963 and established a private practice in internal medicine. They have been in practice in Las Vegas since that time. The practice was expanded with the addition of their son, Dr. Loring Jacobs, in 1985, their daughter, Dr. Leslie Jacobs, in 1988, and their son-in-law, Dr. William Shoemaker, in 1989.

Dr. Jacobs has been active in a number of medical organizations, as well as involved in furthering the arts in Las Vegas. He has been a member of the Nevada State Board of Medical Examiners since 1975, and president of the Board since 1980. He has taught in the Internal Medicine Residency program at University Medical Center since 1980 and has been a clinical professor of medicine for the University of Nevada School of Medicine since 1981.

Theodore Jacobs: I was born on February 12, 1930 in North Bergen, New Jersey, which is in Hudson County. Virtually it's suburban New York City just on the other side of the

Hudson River, so it's very close to New York City. Those areas, both Hudson and Bergen County, were called the bedroom of New York City because a lot of people would live on the New Jersey side, then commute every day to New York for their employment.

I was the second child of three of David and Pearl Jacobs; I was the only son. I have two sisters, an older one and a younger one, both of whom are still living, fortunately. Both of my parents have passed away. My mother was a homemaker; my father was a businessman in the embroidery business. He did a lot of work with the garment district in New York City, producing laces for dresses. There was no one who had been in any profession in my family, immediate family. I subsequently had some cousins who did go to medical school and law school. But prior to that there was no medical background in my family, nothing even close.

I guess I was a fairly good student. In fact, I graduated from grade school at twelve, because in those days you could skip grades. I think I skipped four different semesters. I don't recall which ones exactly, but I ended up graduating second in the class. I went to Weehawken High School in New Jersey, and graduated second in that class, also, in June of 1946.

Anita Watson: Was education emphasized in your family?

Oh, yes. Very much so.

Did they see it as a step up the ladder to become a professional versus being in manufacturing?

Yes, every Jewish mother wanted their sons, at least in those days, to become a doctor, a doctor or lawyer. So it was almost part of the ethnic culture then. I'm not sure that still

exists, but at least in my family it did. Three of my grandparents came from Russia, and they were virtually peasants. One of them came from the Alsace-Lorraine district of France, so they were all from relatively peasant families, hard workers. My grandparents came to this country, and both my parents were born here in New York City on the lower east side. Of course, everyone always made a living but they were very working-class type of people.

What about your sisters? Were they encouraged to get an education or to marry well?

They were encouraged in education. My sister, eldest sister, graduated from college. And my youngest sister did not go to college; she started to work. When it was time for her to go to college, my father hit on some difficult times. As I mentioned, he was in the embroidery business, and he owned the factory. He did quite well in that business in the late 1930s and during the war years in the 1940s. But subsequent to that, toward the end of the 1940s, his factory burned down. We don't know why; the cause was never found. But he had all of his goods in the factory, and there were several hundred thousand dollars worth of goods. In those days nobody had insurance, fire insurance; it just wasn't offered for the most part. So he lost, overnight, several hundred thousand dollars, which at that time was a lot of money. Unfortunately, my youngest sister hit that time period in my parents' life and they really couldn't afford to send her to college. I sort of slipped in the middle, in through the cracks. But no, they were always very high on education.

I just missed being drafted into the Second World War because I was a little bit too young at the time. I then matriculated at Rutgers University in 1946 and spent four years at Rutgers, where I got a Bachelor of

Science Degree, majoring in pre-med courses basically.

I do recall that during my time there, most of the GIs were getting out of the service. It was just after the end of the war. The war ended as you recall in August of 1945, or was it September of 1945? Well, the atomic bomb was dropped in August, and I believe they finally signed the peace treaty in September. A lot of the troops were getting out, and they were going to college on the GI Bill. The government sent anyone wanting to have a college education through college. I was sixteen years old, and most of my classmates at that time were twenty, twenty-one, twenty-two, twenty-three years old, so I was sort of like a mascot for them at sixteen.

I subsequently graduated there in 1950 and had a year of postgraduate training in pre-medical courses at New York University. And then was accepted at medical school in 1951 and went to New York Medical College, which was in New York City, and graduated there in 1955. At that time it was called New York Medical College, Flower and Fifth Avenue Hospital. The medical school has since moved from New York City up to Valhalla, which is a little bit north of New York City.

What made you decide on medicine? Anything specific? Did you have a role model?

Well, I always liked science; always enjoyed the reasons why things would work and how the body would work the way it works. I had a biology teacher in high school who was probably the closest thing to a role model. He interested me in science, and he encouraged me to go into science and particularly medicine. I sort of went along those lines and became interested and subsequently, of course, followed up on it. I took pre-medical courses, I liked it, and went on into medical school.

Did medical school live up to your expectations? Was it more or less?

No, it was exactly what I expected. I did not have any false illusions about it. I will say that I knew that it would be extremely time consuming and all, you know. A totally consuming profession. But I didn't get any surprises along the way. Again, as medicine has evolved now as opposed to then, there have been a lot of changes made which I'm not terribly happy about, which I had not anticipated forty years ago. You can't always anticipate forty years. But if I had to do it over again under the same circumstances, I would do precisely the same thing. If you asked me if I were going to medical school today, whether I would do it again — I would have to give that serious thought.

It was during medical school that I met my wife, Parvin Modaber Jacobs. We were first-year medical students. In an anatomy class we shared the same cadaver together and dissected the same cadaver. So it was . . . our meeting was very melodramatic. We became engaged just prior to graduating in 1955. We both graduated; she was in the same year.

Parvin was originally born and raised in Iran, in Tehran. She had a calling, so to speak. In those days, most women were married off at the age of fourteen and just acted as wives and mothers. They did not have any occupation and certainly no profession in Iran at that time. Fortunately, both her mother and father were very intelligent people. Her father was chief of staff of the army under the Shah. Parvin had a desire to go into medicine. They permitted her to then go to London to high school and subsequently to the United States to college and medical school. There had been no physicians or anyone associated with the profession of medicine in her family prior to that. She was one of the first women who left

Iran to get an education out of the country, to go into medicine.

At any rate we were engaged in 1955, when we graduated. That was the first year, 1955, when they developed a matching plan. All the interns or prospective interns would choose, in order of their preference, hospitals where they wanted to have their internship. Then the hospital would number from one to whatever their preference of whom they would like. It was thrown into a computer to see who matched, how well it would match. Prior to that, you would just apply to certain hospitals, be interviewed, and either be accepted or not accepted.

Under whose auspices was this created?

I guess it was under the auspices of graduate medical education at the time, but I'm not 100 percent certain of what committee. It's usually a joint committee between the association of medical schools and the hospital association. But I'm not quite sure in those years who actually did the matching. That was the first year.

Unfortunately, you could not go in a single unit unless you were married, and they didn't recognize that engaged people could go in as a single unit. I matched at Bellevue Hospital, Cornell Division of Bellevue Hospital in New York City, and she matched at the University of California Hospital in San Francisco. So we were about three thousand miles apart during that year of internship. I had six months of internal medicine, six months of pathology at Bellevue Hospital from 1955 to 1956. She interned in OB with a six-months internship in OB/GYN and six months in internal medicine at the time.

Why two?

Well, in those years it's not exactly the way it is now. First-year postgraduates now sort of have to choose what specialty they want ahead of time and then subsequently go into it. In those years — and that's why they don't call it internship anymore — in those years internship was sort of like a trial period. Most people took a rotating internship in which they took two months of six different specialties and then would decide what specialty they wanted. Some people had an idea what they wanted ahead of time, and would go into a straight internship where you could have, then, a year, an internship before your internal medicine. Then there were split residencies, where you would take six months of one specialty and six months of another. So it was very different at that time.

Were you debating between internal medicine and pathology or . . . ?

No, I sort of knew that I wanted internal medicine. But I also thought pathology was important in internal medicine, and I knew I would not really get a sufficient amount of pathology, anatomic pathology, or histopathology if I went into straight internal medicine. That's the reason I took six months pathology, so I could get some training in that. My wife had a split internship, because she wasn't quite sure whether she wanted to go into OB/GYN then or internal medicine. She subsequently decided to go into internal medicine.

By 1956, when I finished the year of internship, I had visited San Francisco a couple of times during that year and liked San Francisco and liked the hospital. So I then applied and was accepted to the internal medicine residency at the University of California Hospital in San Francisco, where my wife was. She decided to go into internal

medicine also so we both went through three years of internal medicine residency at UC Hospital in San Francisco. Again, in those years you'd have a year of internship and then three years of residency in internal medicine. Right now, it's just three years without the year of internship, so it's really one year less of postgraduate training.

We then got married in February 1956, during the middle of our internship, prior to my joining my wife in San Francisco. She became pregnant and had our son, who was born in the latter part of 1956. Our daughter was born the latter part of 1958. So our children lived their first few years in San Francisco.

And your wife went through residency?

Parvin went through residency during that time, and she worked during both her pregnancies. She was in her residency right up until the day that she had her first labor pains. As a matter of fact, the funny anecdote just for your ears, basically, was we had a journal club there. Oh, about once a month, each resident was assigned to read a journal, and then give a synopsis of all the articles from the journal that they were assigned. They were journals like the Journal of the American Medical Association, or the Annals of Internal Medicine, or the American Journal of Medicine, or the Archives of Internal Medicine. And we would present that synopsis, a different one every month. With Parvin's first pregnancy, when she went into labor with our son, one of the fellow residents was just getting up and giving his synopsis. Two years later exactly the same resident was giving his synopsis in his journal club when she went into labor with our daughter, the second pregnancy. But she worked right up until the time she went into labor and

then took . . . she always saved her two-week vacation for after delivery. So she was back in two weeks both times. As a matter of fact, she's never missed a day in the office since then.

We loved San Francisco and we got a great education there. We were very, very happy. San Francisco was a very exciting town in those days, too. Berkeley was a hotbed at UC across the bay, and the North Beach area of San Francisco was just starting out. The Haight-Ashbury area was just beginning to become the Haight-Ashbury and so it was a very exciting time in San Francisco.

Plus we were on duty about every third night, a lighter schedule than when we were interning when we were on every second night. You'd work all night and have to go all day until at least 5:00 p.m. the following day. It's not like it is today, particularly in New York City, where they passed a law that said if a resident is up all night, they can't work the next day. But those laws were not even considered in the days that we had our postgraduate training.

Is it an endurance test? What's the thinking?

Well, it was a combination of reasons. Number one: we were cheap labor, and there was nothing we could do about it. We didn't have the unions or anyone representing us. Plus, I don't know if it was a rationalization or not, but I think there's some truth to it: they felt that if you could pass this endurance test, you could probably get through your professional life OK. If there was any weakness in your mental and physical endurance, you might have a hard time out there when you got out into practice and into the trenches. So it was almost like putting the marines through boot training to see if they could take it. If they couldn't then they would send them to another branch of service if they

weren't going to be a marine. And I think that a lot of their thinking at that time was to put interns through this endurance test and see if they can handle it. And if they can, then they will probably do OK the rest of their lives in practice. That could be rationalization, but I think there was some truth to it, because once you finished those years, nothing seems too much of an obstacle.

Did you have a high drop-out rate?

It was a moderate drop rate. Usually the drop-out rate would occur in the first year of medical school or during the first year of residency — after the first year of either of those. They dropped out sort of early on; it was too much for them to handle.

That's an interesting start to married life, family life and your career — high stress.

Yeah, definitely, particularly after going through that and then having two young children. Even the nights off we had, they wouldn't always sleep through the nights, so it was a real trial period for us. But when you are young, you can do it. At my age, I couldn't quite handle that right now. In those days it just went with the territory.

And then you joined the army after your residency.

Well, everybody had to go into the service in those years, but if you were going to a professional school, you could put it off until after you got out of professional school. You could be deferred because the services also wanted doctors and other professional people, and at that time we were not directly in war. I started just before the Korean War started, and was still in training during the Korean

War. So I was able to be deferred until after I finished my training. But if you were deferred rather than having been drafted for two years, you would have to sign up for a third year. So they would get three years out of you rather than two years. It made sense to me at the time, and so I was deferred. I was able to get through my full training, then I did have to serve my three years in service.

Prior to finishing my residency I became very interested in bullfighting, the art of bullfighting, for reasons I won't go into. It's a long, relatively boring story. Not boring, but long. And probably not pertinent to what we are talking about. But at any rate, I did get interested in bullfighting. Very interested. I remember every Sunday night we used to go to a bar in San Francisco called El Matador. I don't know, it may still even be there. It was owned and run by a man named Barnaby Conrad. And Barnaby Conrad had worked in the diplomatic corps in Madrid for a number of years. He had become interested in bullfighting during his time in Spain and actually became a professional bullfighter there. He was the man who wrote most of the books in English on bull fighting. Every Sunday night he used to show bullfight movies from the 1940s on some of the great, great bullfighters and of their fights. So we used to go whatever Sunday night we were able to, to see the bullfight movies.

I developed an interest in that, and when it was my time to go into the service, I found out the name of the colonel who made the doctor's assignments. I flew out to Washington one day, and I had an appointment with that colonel. I told him that I was interested in going to Spain. If there was an opening there for an internist, I would be very happy to go there; and I volunteered to go there. He said he would look at it, and if there was an opening

coming up for an internist he would definitely give it serious consideration.

I said, "Fine, thank you." And about two weeks later I got a telegram saying I was assigned to Torrejon Air Base in Madrid. There was one other proviso: if you wanted your family to join you overseas, you would have to sign up for another year. So that was for four years then. Having been assigned to Spain, I didn't mind it at all. We left San Francisco on July 1, 1959, and spent three months in Montgomery, Alabama, being indoctrinated into the air force: marching, shooting rifles, and learning all the things that are necessary to learn about military life. Then in October of 1959, they flew us on the transport plane, myself and the whole family, to Madrid. We were in Madrid from October of 1959 until we left in the summer of 1963.

The children were quite small then?

They knew Spanish before they knew English pretty much. Torrejon Air Base was the big Strategic Air Command base in Europe. Just outside of Madrid, it's about a forty-five-minute drive out of the city. It was a really plush base. In those days Strategic Air Command was king; they gave everything to SAC. The officers' quarters were actually about forty-five minutes from the air base in a little suburb outside of Madrid. They had some very comfortable officers' quarters, homes. And the officers' club was very plush. We were all treated very nicely there.

Did your wife work as a physician while you were in Spain?

The hospital commander at the air base did not like women doctors. She applied, and he said that there really was no room for her. Of course, we knew differently, because they

were hiring Spanish doctors to take care of the dependents of the air force personnel. So she went down to the University of Madrid School of Medicine and volunteered her services to make rounds with their residents. At that time she wasn't fluent in Spanish. She knew some, because we learned Spanish prior to going there when we were learning about bullfighting. We had learned Spanish so that we could read some of the books that were written in Spanish. But she wasn't overly fluent at that time, and so they would have an interpreter for her. She would make rounds at the University Hospital there with their resident. She had completed the residency, so she devoted her time to doing that, to keep her fingers in things, to be able to see some patients.

And then — oh, maybe about nine months later — there was a big cocktail party in the officers' club one night. The guest of honor for that particular party was the chief of staff of Strategic Air Command, a four-star general. During the course of the evening, of course, we were introduced to him, and she went up to the general and said, "General, I'm a fully trained internist, and do you realize that you people here at the hospital cannot take advantage of my training?"

He said, "What do you mean? Can't we find a job for you to take care of dependents?"

And she said, "Well, apparently the hospital commander doesn't think so."

So the next morning, the first thing, I was called into the hospital commander's office, Colonel Hoffman. And he said, "Dr. Jacobs, I understand that your wife is a fully trained internist. And I think we can use her." So subsequently she did get a civil service commission appointment, and she was a GS-13, equal to a lieutenant colonel, which outranked me. I was only a captain. She took care of dependents for the rest of the time,

three years, that we were in Spain. So that's how she got — that's how we managed to get her that job there.

She had to assert herself?

Yes. Well, she's very assertive.

That's interesting, given her background in a Middle Eastern culture.

Well, she didn't know any English when she came over to England at all. She knew French because French was the diplomatic language in Iran, the second language, so they all knew French fluently. But she really didn't know any English other than a few words. You know, "hello," "goodbye," "how are you," and that kind of thing. So she had to learn English from scratch when she was going to high school in England. By the time she came to the United States, she was fluent in English. So it was difficult. But she's a very unusual, dynamic woman.

It was a great four years because we loved Spain, loved the Spanish people. I got to see 107 bullfights.

One hundred and seven bullfights?

Yes. We used to go every Sunday. Every major city has their own fiesta once a year. For example, the one in Valencia is in March and the one in Seville is in April; the one in Madrid is in May. There are some in June, and in July there is the big fiesta, the famous one in Pamplona, in northern Spain. It's a small little town in the Pyrenees. The fiesta starts on July seventh of every year. Seven minutes after the seventh hour of the seventh day of the seventh month. In the morning, that's 7:07 a.m., you hear a cannon go off, and they run the bulls

from outside the city through the streets. I'm sure you've seen pictures of it.

Did you run with the bulls?

Yes, I ran with the bulls. [laughter] Yes. Rooms are at a premium; the place is mobbed during that eight days when they have their festival. Fortunately, I was taking care of our ambassador to Spain at the time; he was able to get accommodations for us. We had a little balcony right overlooking the street where they run the bulls. So we were fortunate in there. I just did it one of the eight days, not every day. Just wanted to get the feeling of it.

And what was the feeling?

It was an exciting feeling. Again, you have to be young, and perhaps deficient in intellect to do it in the first place, but it was just part of the whole atmosphere. And I guess I could then tell my grandchildren that I once ran the bulls. As a matter of fact, I took bullfighting up there myself, I was so into it.

The anesthesiologist at the air base was a Spanish hire, and he was the anesthesiologist for the bull ring in Madrid. So he knew all the bullfighters. And they did not like to teach Americans. But I had learned so much about it, I actually wanted to learn the technical part, the art of it. So he found an old bullfighter for me to take lessons from — along with a lot of young eleven-, twelve-, and thirteen-year-old Spanish kids. I was the only American, and the only adult among the kids that were learning from him — but I did have a good feel for it. He used to take us all up every Sunday afternoon to some little pueblos, myself and the little Spanish kids. I used to buy a calf for them to cape for the afternoon.

So I got bumped and banged around a lot. They were only two-year-old calves and their horns were not well developed; they were still stubby and not pointed, so they couldn't quite penetrate. But when they hit you, it felt like you were hit by the Pittsburgh Steelers defensive line. So they could bang you up a little, but they couldn't penetrate the skin so you couldn't actually get gored.

My understanding is that if a calf has been used for bullfighting, they don't do it after they become an adult because they are then dangerous?

The real bulls they use in the bull ring with professional bullfighters have never seen a man on foot before. On horseback they have, but they haven't seen a man on foot. Bullfights generally only last about eighteen or twenty minutes, but even during that eighteen or twenty minutes they begin to learn that the cape is not their enemy but that there is something more than the cape. As the fight goes on, they become increasingly more dangerous because they are also beginning to learn. Yes, that is a fact that they never use bulls that have fought before — and the reason is that they would be very dangerous if they were caped before. Of course, most of the time the bull is killed in the bull ring. I think there have only been about three, maybe two or three, occasions in the history of bullfighting where the bull has been so great that they permitted it to live.

Traditionally, isn't the bull given to charity? Or is that a story? A myth?

Well, there was an abattoir right behind the bull ring, and so they usually cut it up for meat and sold it at a very cheap price, at a very inexpensive price to the poor people.

Are you still interested in bullfighting?

Still interested, but we haven't seen one probably in about twenty years. We did go back to Spain in 1974 to visit some friends, and we saw two other bullfights in Mexico subsequent to that, but it's been fifteen or twenty years.

It's a very religious ritual. Most people just see the killing of an animal. I can understand that, but on the other hand, if people are not total vegetarians, somewhere along the line an animal is being killed. But there are a lot of religious overtones in the sense that it's not man killing an animal, but it's man conquering his own weakness and his fear and doing it in an artistic fashion. And so then it becomes almost a religious ritual such as Christ dying on the cross for the weakness of man. As a matter of fact, a very key point in the killing of the bull is when you have to make a perfect cross with your arms. To make a perfect kill, you lead the bull in with your left hand with the muleta, and you go in over the horns with your right hand, and at the time of the kill you are making a perfect cross. So you can bring that religious part into it. It may be an oversimplification of it, but they often talk about making a perfect cross at the time of the kill.

I've spoken to a lot of bullfighters, and all of them are afraid. Every one of them are frightened to death on the day that they have to fight. First thing they do when they wake up in the morning, on Sunday morning when they're fighting, is to look outside and see if it's windy. The wind is a terrible enemy for them because the wind moves the cape. If a gust of wind comes along and moves that cape toward their body at the wrong time, it can be tragic. But they conquer that fear and do it in a very artistic, graceful way. And so I've talked to a

lot of people about it, and a lot of bullfighters and people understand the art.

What about when you finished in Madrid and decided to go into private practice? What did you consider at that time? How did you decide on Las Vegas?

When we were in Madrid, one of my patients was a retired army major by the name of Temple Fielding. Temple Fielding wrote Fielding's Guide to Europe. It is probably the most famous guidebook — it was one of the original ones and it's probably been one of the major ones since the 1940s. He was a retired army major living on the island of Majorca, a little island off Spain. He had high blood pressure and would come up to the air base hospital every six months for a checkup. We got to know each other and were very friendly. So every time he would come up to Madrid he stayed a week because he would have to review the restaurants and the nightclubs and the hotels, you know, for the next year's book.

A tough job.

A tough job but somebody had to do it. So he would always tell Parvin and myself, "Why don't you come and join me? I've got to go to five restaurants tonight and three nightclubs and keep me company." So whenever he'd come up, we'd go out with him every night for a week if we weren't on duty. We got to know him very well and became very friendly with him.

He had a young editorial assistant at that time by the name of Joe Raff. So we got to know Joe very well because he would come up often with him, and we saw him at the times we visited Temple down in Majorca. He was married to a girl by the name of Judy, and Judy's parents owned a radio station here in

Las Vegas in those days. Mr. Oberfelder had many years experience in the broadcasting business. Actually, he was one of the very first ones who started call-in radio, where people would call in during programs. He was the first one in this city, and one of the first ones in the country, to embrace the concept of call-in radio programs.

A few months before we left Spain, the Oberfelders were visiting their daughter and son-in-law in Madrid, and we all went out to dinner one night. I was getting out of the service and we were going to go back to San Francisco to practice. As a matter of fact, we already had jobs with an internist in San Francisco.

During dinner Mr. Oberfelder, the one who owned a radio station here, said, "You know, Las Vegas is a growing area, and you really ought to take a look at it. It's really going to take off and boom, and it's not just a little gambling city anymore."

I said, "Las Vegas? You've got to be kidding! After my poor parents spent all that time and money getting me through medical school and all of that, how can I go back to my parents and say I'm going to practice in Las Vegas?" I said, "I just can't do that."

He said, "Well, think about it and take a look at the area, and I'm telling you, you'll be doing the right thing."

So I told my parents I was going to visit here, and the possibility existed that if I liked it I might want to stay. In the meantime, I told the people in San Francisco that I wasn't 100 percent sure that I was going to be able to join them there. We came out here in the summer of 1963, in the middle of the heat. My wife didn't particularly like the hot weather at the time. She was not too enthralled about living in the desert.

We looked the area over, and I thought it showed a lot of promise. There were only

five internists here at the time in the city, and in the whole valley there were about ninety thousand people. We thought we'd stay. We had nothing to lose; we could always go back up to San Francisco and get a job or practice if we didn't like it here. So we decided we'd stay.

You know, we didn't know anybody except that one family who was living here, the gentleman and his wife who owned a radio station. And then we became the sixth and seventh internists in Clark County at that time. The funny thing was a few years back I was chief of medicine at Sunrise Hospital. I had 220 internists in my department. Of course, there were sub-specialists by then; we didn't have sub-specialists in 1963. So there was quite a change.

Did you and your wife open your own practice?

Yes, we opened up our own practice. Unfortunately, when we made the decision to come, we didn't get here until the very end of August. At that time I really didn't know how the Board of Medical Examiners in this state worked. They had a meeting, I think the very first week in September, to license the doctors, but it was too late for us to put in applications at the end of August. So we had to wait until the December meeting to get licensed. In the meantime, the Nevada Test Site was looking for some help in the medical profession to do physical examinations on the test site personnel. So we applied and started working, I guess towards the end of September, at the Nevada Test Site until we could get our applications in and go through the interview in December with the Board of Medical Examiners. So we were licensed, then, in December.

Las Vegas then really didn't have much in the way of office space — there was only one medical building in town at that time that had

offices. That was next to Southern Nevada Memorial Hospital, which is now University Medical Center, but the offices were all filled. Sunrise Hospital was putting up their first medical building adjacent to Sunrise, which is 3196 Maryland Parkway. And that was not going to be completed until November of the following year, November 1964.

So we decided to get a suite in the new building when it was completed. In the meantime, we found a little office to open up. It was a very small. We didn't even have separate rooms for the examining tables. We had to put up screens between my patients' examining table and my wife's patients' examining table. So it was difficult. The first year was a difficult year, getting started because of these facilities — you know, we had to start off with buying all the equipment. Of course, we had zero patients, and we had no contacts in town. But we managed to get through it. And then we moved into the office building next to Sunrise in November of 1964.

Your family is in medical practice together. Did you encourage your son and your daughter to go into medicine?

We never told them that this is what they have to do or should do, but we didn't discourage them. Above all, they knew what the exigencies of the medical profession were because the one thing we insisted upon with the family was that we would all have dinner together because we were gone all day. My wife was gone all day, plus night calls and telephone calls, but the one thing we did insist upon was that we all had to have dinner together at the dinner table. At least at that time we could communicate with each other. And there was a hardship on the kids often because sometimes we wouldn't get home until 7:30, 8:00, 8:30 at night; you know, kids

want to eat a lot earlier than that because they're hungry.

So they were quite aware of what they would have to go through, and it seems to me that they were interested in medicine. And we would talk about things around the table all the time, and they would always ask questions. They decided to go into it. The one thing we demanded from them was not that they go into medicine specifically; we did demand that they had to do something productive. When they were growing up, there were still a lot of the "flower children" around trying to find themselves. One thing we said was, "You better find yourself right now because we're not going to let you go out to try to find yourselves, to find your head, because I'll show you where your head is." So we did demand that they would be productive, although not necessarily go into a specific profession. But I guess their natural proclivity was to go into it, and they enjoyed it and liked it.

And all internal medicine?

You know, actually when my wife decided to go into internal medicine, we discussed it, because a lot of people said, "No, you don't want to go into the same specialty; you'd be competing with each other." Well, we didn't exactly look at it like that. The same thing with the children. We discussed that, particularly after the experience that my wife and I had working together. We really weren't competing with each other; we complemented each other in a sense. We had similar interests. We discussed cases, had consultations with each other. It worked out very nicely, in a much nicer way than we had anticipated. We told the children that if they did not feel that they wanted to go into internal medicine, don't. We thought it was

the most interesting specialty and still do. It's not a competitive type of thing at all. But it's fun and helpful to have the same interests. As a dividend, now we have them to give us a helping hand; give us some free time which we didn't have before.

Both of our children went to undergraduate school at USC, and they both went to Loyola Medical School just outside of Chicago. And they both had their residencies in the University of California Hospital System, one in Irvine and the other in Los Angeles. So we all came out of the University of California System in our postgraduate training. Right after his training, my son joined us in 1985, and three years later, in 1988, my daughter also joined the practice. The year after that my daughter married Dr. [William R.] Shoemaker, who was a resident in the same system at UC Irvine with her. He was in internal medicine and became the fifth member of our practice.

Could you tell me a about the your first contact with the Board?

Well, I mentioned that when I first came out here in August of 1963, we didn't really have sufficient time to put in an application because the State Board meeting was in September, so we couldn't get the application in in time. We finally did put in an application, and in December 1963 we were licensed. I believe we flew up to Reno for the oral interview. It was an interview session at that time by all five Board members. As I recall the Board examinations consisted of their asking, both my wife and myself, consultative questions. They wanted to know what to do with some problem patients. Since they had specialists in internal medicine, they took advantage of the situation, and we gave them free consultations.

So this was a real life situation?

Yes, their own patients. They wanted to get curbside consultations from us relative to some patients that they actually had seen recently and who were perplexing them.

You've been on the Board for twenty years. And now you're taking part in this sort of thing. Has the examination process changed a great deal?

Oh, we went through a metamorphosis of a variety of types of examinations. Originally, when I first got on the Board, all the Board members would examine each applicant at the same time, asking them a variety of questions. I guess for the most part, depending upon what the specialty of the individual Board member was, in a sense, they would gear their questions toward the specialty. This got to be pretty cumbersome. Our Board was sometimes made up of two urologists at the same time, or two pediatricians, and an internist. If you had a neurosurgeon applicant, nobody could ask him any reasonably good questions because none of us were neurosurgeons.

The Board also got unwieldy because the amount of applicants increased over the years. Now, all the Board members getting together in one room and questioning each applicant individually became very, very difficult as these numbers increased. We subsequently decided to invite Board-certified specialists in various fields to question the applicant. Usually what we would do would be to have two Board-certified specialists, for example, neurosurgeons, question another neurosurgeon, so they could be speaking on the same levels. Same thing with two internists examining the applicant who was a specialist in internal medicine. Usually the oral exams would be anywhere from thirty

to forty minutes. They were sometimes very grueling, although we told the examiners that the difficulty of the questions should not be on a Board certification level. It became quite subjective, and it was sometimes difficult to determine whether or not they should pass or fail the applicant because the Board members themselves had the final say. But the two examiners who were not Board members, who were invited in just for that day — sometimes one felt that the applicant should be passed and the other that he should be failed. Sometimes they thought the applicant's knowledge was very questionable, and had them come to the Board directly to ask questions to see whether or not they were qualified for licensure. We soon got a reputation around the country, I think, of being an extremely difficult state in which to get a license. On occasion, these examinations were fairly difficult and varied from examiner to examiner, so there was no real objective nature from one group of examiners to another group of examiners.

However, it seemed to work fairly well until one day our two invited examiners were questioning someone who had specialized in internal medicine. And they came back to us and said, "In no way can we give this guy a license. He just doesn't seem to have it. And we feel, both of us feel, he should fail. There is just no way that we can pass him on his exam." We looked in his file, and we found out that had he just passed the American Board of Internal Medicine examinations a few months previously, which are very difficult exams. It made it very difficult for us then to go to the applicant and say, "Listen we know you passed the American Board exams just a few months ago, and now we in Nevada don't think we can pass you."

He'd say, "What's the matter with you, you crazy?" So after this happened, our legal

counsel, Larry Lessly, said that this wouldn't do. We were going to end up getting into all kinds of legal complications with something like this and end up being sued. Because of the subjective nature of the panel, we had no foundations to stand on. He said we must have some type of objective examination. So we then formulated some objective examination and went back to the format of the Board members doing examinations for the most part. But everyone would have virtually the same questions to ask with an objective set of answers that we could go by.

We've been doing that probably for the last three years. The questions were relatively easy, and Dr. Scully, I believe, then analyzed how many people we failed on the oral examination over that three years with that format. We found that we had not failed anybody. So at a meeting earlier this year in the spring, we decided, "Well, since we've now gone through several hundred applicants and not managed to fail anyone on the basis of these relatively objective and easy questions, why don't we just do away with them entirely?" Because it wasn't accomplishing what we wanted it to accomplish. And so at that meeting earlier this spring, the Board voted to do away with the oral examination and just go on the basis of their credentials. They still do have to take an open-book written examination on the statute that governs us, the Medical Practice Act, NRS 430. It's just so they familiarize themselves with the rules and regulations in the state. So that's the metamorphosis that has occurred over a period of time.

Is it the feeling of the Board that because these people have gone through medical school and then three years of postgraduate training, that they have already passed exams and have been evaluated?

Correct. There is a provision in the statute to license an applicant who has passed all necessary exams and had three years of postgraduate training in an approved residency in this country or Canada. However, if they have not taken a formalized type of written examination in the past ten years, they can do one of several things: they can be recertified in their specialty; or they can take and pass Part III of what was the FLEX exam and now is the USMLE; or take an examination called SPEX, which was developed originally by the California Medical Association but in conjunction with the National Board of Medical Examiners. SPEX is a formalized test which a lot of boards use to determine medical competency. It's a generalized test, but is an objective formal written test. So they have three potential ways if they have not had a formal exam within the last ten years. If they were Board certified within the last ten years they would not have to go through that.

It seems as if in the past the oral exam was a way of getting to know the candidates.

Yes, it served several functions. Number one, it permitted us to make sure that the person at least was not an overt paranoid schizophrenic. Number two, we got to know a little bit about the candidate, as well as their competency, through the way they answered the questions. And it also showed that the Board was interested in them as an individual on a one-on-one basis so there was some person-to-person contact — an interpersonal relationship which we felt was good. And it was. It's just that the number of applicants are so numerous now that it becomes onerous to do it on a one-to-one basis. And we still have had no really good way of developing some

type of objective test on the basis of only a thirty-minute examination.

When you were talking about your experiences with your medical education, you said that you did one year of internship; then you did a three-year residency. Now the requirement is three years postgrad, which is essentially one year less. However, medical knowledge has taken tremendous strides. Is there an inconsistency there?

Yes, there is somewhat of an inconsistency there. But originally, as it evolved, the year of internship was giving the individual one additional year to determine what specialty he wanted to go into. For the most part, it was intended to be a rotating type of internship in which they would do two months of every specialty. They would get a little smattering of it that way, and then it would be easier for the student to determine what specialty fit him the best. Subsequently, in more and more medical schools, in both third and fourth years, the student tends to have more patient contact than they did in the earlier years, so that they could make their determination sooner about what specialty they wanted to go into. So it sort of evolved in that sense. And they did develop a straight internship in which you then would still be called an intern, but it would really be the equivalent of being a first-year resident. So the residency in reality was then four years long.

Why it was cut down to just three years of postgraduate training, I'm not sure. I know that originally the hospitals loved that extra year because they got cheap labor out of the doctors for one extra year the way it was before. So I'm not really sure of why it evolved to just a straight three years rather than a four-year program. But there are some

specialties that require more; general surgery is still four years, not three. And neurosurgery is probably about seven years. So it depends upon the specialty.

There are other issues specific to the Board around your time as a member that I'd like to discuss. In the early 1970s a mention was made of a Healing Arts Board, trying create an umbrella program to oversee all of the medical licensing and examination process. And it was rejected. There is mention made of it every now and again. What do you think about the possibilities of something like that?

Well, we've always felt that we would not like an umbrella agency. For one thing, our entire budget comes from the physicians themselves. We don't get any money from the state. Therefore, if the doctors are contributing the entire budget to the Board, we feel we should have control over it. Once you get into an umbrella agency, you lose control, and whoever the czar of that particular umbrella agency happens to be will have the control. In addition, a lot of the other boards do not have quite the amount of revenue that we have, so we would end up supporting other boards, which we also didn't feel was fair. If the state wanted to supply the revenue for that particular board because they didn't have enough money themselves to run their own organization, then, fine, the state should have some kind of control over it. But since it was not that way in our case — we didn't want to lose control — we didn't want the state handling the purse strings. Because the person who handles the purse strings usually ends up dictating to that organization or the Board.

The existence and the licensing of physician's assistants. How do you feel about physician's

assistants and the Board's involvement with them?

Well, I think we felt strongly about the beneficial role of physician's assistants, particularly in the rural areas, where you could not get M.D.'s or D.O.'s to locate. This whole physician's assistant program really got started to help out the rural areas. And we were all in favor of that. As it subsequently evolved, more and more of the physician's assistants were going into urban areas. Being assistants to doctors in urban areas was not quite the original concept. Still, there was nothing you could do about it. But you know, I have no objection to the physician's assistant program. The paper trail has become more and more burdensome to doctors. Physician extenders can be quite helpful in doing a lot of the screening for them.

I think all of us on the Board have been very impressed with the quality of the physician's assistants, for the most part, that we have seen over the years. We've had very little problems with the physician's assistants themselves. Some of their problems have been from lack of proper supervision by supervising physicians, but that's a different story. We've made every attempt to emphasize to the supervising physicians that they have to supervise and be in close contact. And I would say overall we have not had major, major problems. So in this state it has worked out fairly well.

Acupuncture — that was just before you came on the Board, I believe, 1972, 1973. The legislature certainly got into it and got involved. The objection of the Board when they created a position paper was that very little about the procedure was understood by Western medicine. There were also concerns expressed about masking of symptoms, treating

the symptoms rather than the underlying cause. There are connections made between all sorts of irregular types of medicines with homeopathic medicine, naturopathic medicine, et cetera. What role do you feel those types of healing arts have in the practice of medicine or the Board's responsibility towards the public?

Well, relative to acupuncture, Western-style medical thinking doesn't quite understand it. One has to be impressed with certain case studies that come forward and how efficacious it is in certain instances, particularly in the delivery of anesthesia. But East is East and West is West, and ne'er the twain shall meet. And I just don't think that our thinking is on the same wave length as Eastern medicine is. I think people should be given freedom of choice if they so desire. They should be masters of their own destiny. The major hesitations I would have would be in the delay in diagnosing and treating some underlying serious disease because someone was spending a long period of time with acupuncture.

The one thing I could not understand about acupuncture is that if all these forces that exist within the body that acupuncture attacks for the benefit of the patient — if for some reason those needles were put in in the wrong places, why wouldn't that have a negative effect? Why would it always have a positive effect and not a negative effect if and when those needles were not put in the right places? I have often wondered about that, and I've never gotten really good answers. Certainly, if we used wrong medications in our patients in certain cases, we may get negative effects in the disease process. It always seems that people who espouse acupuncture never discussed the possibility of ever getting any bad results because of misplaced needles.

But I do think people should have certain freedoms of choice, as long as they go into it with a reasonable amount of knowledge and understanding that there has been no scientific basis for it. And the anecdotal examples are sometimes quite compelling. As for other forms of unorthodox-type treatment, again — we feel strongly that we cannot endorse it. On the other hand, people should have freedom of choice.

There were a couple of times when you've met with the naturopaths and the board of homeopathic medicine. Proposals have been made that the boards be combined. In the Board of Medical Examiners' response for the homeopaths — you pointed to basic ideological differences. And this was recently, in 1987. There's an age-old conflict between regular medicine and the so-called sects, as they were referred to historically. Like acupuncture, do you think it is something that is just too far off on the different ends of the spectrum and understanding of the body and treatment and illness? Or is it something that could converge at some point in time and work together?

Well, I think all our patients, you know, are different, particularly with homeopathy. There's never been what we consider good experimental studies to indicate that the nature of their treatments are helpful. Obviously, some of the improvements may be placebo. In allopathic medicine, we get a lot of placebo effects from giving medication that probably isn't helping at all but at least when we are giving it, we're backed up with some double-blind studies, controlled studies, what we consider scientific studies. Homeopathy, to my knowledge, is all anecdotal, and there are no double-blind studies that have been done in the past.

Some of the medications they use are from herbs, plants, et cetera. A lot of allopathic medicine is also obtained from herbs and plants. Digitalis is one of the major drugs used in heart disease, and it comes from a plant. Quinidine comes from the bark of a tree in southeast Asia. One of our very popular anti-hypertensives that has been used over the last decade, angiotensin converting enzyme inhibitors, ACE inhibitors, which are very potent anti-hypertensives, comes from the venom of a South American snake. It is synthesized from that, and the reason the venom was lethal when administered by the snake was that the blood pressure dropped dramatically within a matter of minutes, and the person would die in shock. Well, obviously we try not to give lethal amounts, but all the same it did come from the venom. And there are numerous, numerous plants that medications come from. Penicillin came from a mold in nature. So there may be some basis for some of the medications that they use for whatever malady they're treating, but there have been no scientific studies that have been done. So it is difficult to espouse that kind of medical philosophy. And certainly the Board would not want to be responsible for them when we don't agree with the entire philosophy of the treatment.

An issue that was controversial with doctors is CME, Continuing Medical Education. Should it be mandatory? Should it be voluntary? When the issue was first raised in 1975 or so, most of the doctors felt that it shouldn't be mandatory. In a study done by the Nevada State Medical Association, doctors who responded were overwhelmingly against it. Well, now it is mandatory. How do you feel about the whole issue of Continuing Medical Education?

Well, you know, I originally felt that those who do, do and those who don't, don't — that

in a sense, without it being mandatory, most of the doctors who keep up with current events in medicine would be up-to-date, and those physicians who generally did not keep up with modern trends wouldn't do it. Those who did not have a natural proclivity to keep up with Continuing Medical Education, if they were forced to, they might go to a meeting and sign in and never go to the actual meeting itself — go out and play golf or tennis or whatever, or shopping with their wives or fall asleep in the meeting. But they weren't really absorbing what Continuing Medical Education was meant to do. So basically I did not feel that making it mandatory was going to help.

Certainly it would be a good public relations tool because the general public would be aware of an attempt to do this. But from a practical point of view, I don't know whether it was successful in that or not. On the other hand I think that there are some who probably fell through the cracks, who perhaps weren't keeping up with Continuing Medical Education. But now because it was made mandatory, they feel they might just as well make the best of it and go ahead and go to meetings, or listen to tapes in their cars to and from work or at home, and perhaps get something out of it. So after all is said and done, I would have to say that I'm probably pro mandatory CME — mainly for those who are in between who feel they will make the best of it, now that it's mandatory.

What about those who find it difficult to obtain the credits?

It's not any more. There are so many organizations that put out tapes that you can listen to at your leisure. I do in the car going to and from home and the hospital all the time. It's about an eighteen-minute trip from

here to the athletic health club that I use two or three times a week to exercise. That gives me a good thirty-six to forty minutes of tape, just listening to tapes three times a week while going to the health club, to say nothing of the everyday use whenever I'm in my car. If you answer certain questions, you mail can them in and get credit, so it's very simple now to get CME. It is no longer a situation in the rural areas, where you have to travel a hundred miles to the nearest hospital to catch one hour of CME on a lunch break. So I don't think obtaining CME is a problem now with all the tapes that are available.

But this is a relatively recent development?

Oh, no, tapes have been around, God, for a long time. I don't recall when they first started making them, but it must be at least twenty years. At the beginning, you only could obtain tapes from perhaps some of the large meetings like the American College of Physicians, the American College of Surgeons. But then shortly thereafter, Audio Digest, which was sponsored by the California Medical Association, had twice-a-month tapes coming out. Now they have tapes from many, many meetings and a lot of organizations that specifically put out tapes for CME.

Does this replace, to a certain extent, the physician who sits in his study in the evening reading the medical journals? Or is it in addition to?

I think it supplements it; some of them give you a very good synopsis of what the articles are all about, summarizing lots of articles that have come out. But if you are particularly interested, they always mention the journal it was taken from. You can always go back and read it in detail. There are tapes

put out by . . . in a medical school in New York City. I'll think of it in a minute, but it's really very, very good. And they really keep you up-to-date.

One major advantage in listening to tapes is that they are made monthly or twice a month, so you're getting the very latest. When you read some of the articles, they are about two and three years behind. It takes that long for them to get published in a journal. So a lot of the articles you're seeing in the journals represent work done two or three years previously, as opposed to the tapes that are very current.

The issue of advertising by physicians. It's something that's fairly common practice now, but it was something that was objected to earlier. What are the reasons, do you think, that attitudes toward that have changed?

Good question; I don't have the answer to that. I think it's partially changed, because the public is wanting it to change; that the public feels that they are getting a little bit more information about the physician when he's advertising what his specialty is and what his particular area of expertise is. I guess I grew up during the age when it was not ethical to advertise. I don't think it's unethical, yet I still don't like it. My own personal bent is not to advertise. There is just a certain amount of unprofessionalism about it.

Undignified?

Undignified. Too much braggadocio. Although we do have rules and regulations against misleading advertising, I think it can provide a forum for misinformation.

Even if they're within the guidelines? Do you think, then, it can be misleading?

Well, if it's strictly within the guidelines, literally within the guidelines, probably not. But I don't think that it always is promoted within the strict guidelines. But it's not a sufficient amount for, let's say, the Board to do anything about in a court of law or in a disciplinary hearing.

So where are the shady areas?

There are sometimes nuances of misinformation that are promulgated with advertising, but with nothing that the Board could ever act on.

The Board . . . the ability to take away a person's license and, therefore, their livelihood is a major responsibility. And yet you're balancing that between protecting the safety of the public; that's something that comes out every time you make a position paper; it comes out in just some of the general discussion. Do you think that's something that's become more difficult over the period of time as medicine becomes bigger, as the population grows, or do you think it's something that has always been there? Has it changed?

It's always been there. I think that our main function still must be to protect the public welfare. Balanced off in the last decade or so has been the contention that we should permit people to rehabilitate themselves and help them rehabilitate themselves. There's a very thin line. If there's any question in our minds that the public health, safety and welfare is in doubt, we would act in that direction, toward protecting the public.

It is very difficult to revoke a license from a doctor because you know what he's been through in the past; you have compassion for him. You know the economic loss that it presents to him; for the most part, physicians

really can't do anything else. They haven't had time to hone any other skills. It makes it very difficult — all I can say: it's a thin line; every case is different. I don't know that any license was ever revoked in the early years. But all I know is it was extremely rare for us, my first few years on the Board, to have revoked a license.

There are certain names that tend to crop up over decades with the Board. And I think as much as anything else, that is an indication of how difficult it is to make these decisions, these life-altering decisions. Do you think by the time the attention of an individual comes to the Board, then it has gone to a crisis point? It's not something done over a trivial matter?

Well, prior to 1985, yes, it would have to be a major confrontation. Since 1985 and since we've been able to work with an investigative committee, we have been able to maintain a certain confidentiality. We can call people in even on the relative trivialities when there is a trend. We're probably more able to nip things in the bud a lot sooner now because of that ability to maintain confidentiality than we would have prior to 1985. Prior to 1985 it had to be a major thing to go forward with any formal complaint. Now you have the advantage of calling somebody in, knowing that maybe we can't prove it today, but at least we can let him, the physician, know that we know certain things are going on, and you had better cease and desist. Otherwise, we are going to accumulate a lot of information and go public with it in the form of a public complaint. We weren't able to do that before 1985.

So this is something that you can do in a confidential meeting without facing legal repercussions?

Correct.

So do you think that has improved the success rate with physicians?

Oh, yes, without a doubt. It's something the public doesn't fully understand. Their contention very often is, "Well, nothing should be confidential. The public has a right to know these things." OK. And certainly without the insight of what goes on within the Board, I think that's a reasonable stand to take. But what they don't understand is that it's hard in a disciplinary hearing to prove something and let it stand without being reversed by our judiciary system. Once various attorneys come into the fray — when we suspect that something is going on, we might be able to get them, but we may not. Maybe you can stop things when they are starting, at the point where you still may not have enough evidence to go public with it or it wouldn't stand on a legal basis yet. If it can't be stopped, then, yes, we do go ahead and make it public as soon as we have sufficient evidence to think that we can prove it. And this is extremely helpful. There is not an investigative committee meeting probably that goes by where some people aren't called in to do just this, or at least to give an explanation for what their actions seem to be, what the complaints are. So that confidentiality I think is helpful, in the long run, for the public. The public thinks that we use it to . . . some of the public thinks that we may use it to protect ourselves. OK. It's one doctor trying to protect another doctor. But that's not the way it works.

The attorney that we had when I first came on the Board, Bryce Rhodes, was very nice, but he was not very aggressive. And very often when the Board wanted to do certain things from a legal point of view, he would say, "Well, you're treading on thin ice. I don't

think we can carry this through.” I think a lot of the fact that the Board was not aggressive was the influence of the legal end of it saying, “No you can’t do this and you can’t do that; you’ll run into problems if you do this and that. I don’t think I can defend this or that.” So there was a lot of lethargy from a disciplinary point of view.

I know when I got on the Board, that was not my philosophy. If we were treading on thin ice, well so be it. We would at least attempt to do it and show the doctors that we were going to discipline them. If we got overturned at the district court level or whatever, then we were overturned. But at least we tried.

Bryce was getting older and, of course, eventually retired. That was when Larry Lessly came in, on a part-time basis originally, because he had his own practice. And Larry had the opposite point of view: we should be aggressive but fair. So now it became easier for the Board members to be able to do something and have the legal backing for it, than working with someone who was less aggressive on the legal end. So I think that made a big difference. And a lot of new young blood came on board, you know, which was not the case earlier. Most of the members of the Board when I came on were already, well, you know, late fifties, sixties, early seventies and were a little less aggressive than some of the younger Turks were. And we got younger and younger members on the Board, and they just tended to be a little more aggressive than some of the, quote, “good old boys.” And so it evolved that we became more proactive; we were compassionate and fair, but definitely aggressive.

Do you think, then, that personalities really can affect the direction the Board is going to take?

Oh, without a doubt, without a doubt. There is no question in my mind that it was

basically personality structured, which made the Board more aggressive. That, and, of course, as I said, I think the public awareness of what the Board was doing on a disciplinary basis imposed a certain added need for the Board to become more active. But I think even before that became apparent, it was a natural tendency of personalities.

I know you’ve run afoul with the Open Meeting Law or had complaints. I noticed one complaint by a news reporter who apparently felt that he should be in on one of your meetings.

Well, we had one or two encounters with the Open Meeting Law. I think they were relatively minor. But, of course, now we are excluded from the Open Meeting Law when we adjudicate or at the investigative committee sessions. It’s by statute that the investigative committee can have that confidentiality. But other than that we abide by the Open Meeting Law. There for a while we had to adjudicate the disciplinary hearing in an open meeting. Now, that’s like asking the jury to deliberate right out in the courtroom, in the open — which, if you really get to it, how truthful do you think one juror could be with another if they’re right out in the courtroom?

And their words are a matter of public record?

Yes, they were a matter of public record and you know, sometimes it would be difficult to really speak your mind, the way you feel when you are out there in the public. It made it very difficult and also did not work in the best interests of the public, I thought. One of the best things about the 1985 law was the fact that we were able to adjudicate in closed executive session.

But considering the length of time we’ve been working with the Open Meeting Law, we

have not had too many incidents. I can think of maybe two incidents in which there have been complaints but nothing much. Once we had the attorney general's office slap us on the wrist for something, but I think they were out of line when they did that. Off the top of my head, I don't remember exactly what that incident was, but I do remember I got upset with the attorney general for that; I don't think it was warranted.

You really are walking a tightrope between privacy, confidentiality, and the public's right to know.

The public's right to know — we are aware of that. On the other hand, we feel that we can be more efficacious if we have that bit of confidentiality, as long as we don't abuse it. And to the best of my knowledge, over the years that I've been on the Board, we have not abused that element of confidentiality. If it's abused, yes, I think it's bad. But the manner in which we have used it, I think, works to the public's benefit.

It seems like a number of incidents or problems with physicians have been with fellows who have had problems in other states, who, for example, have not necessarily been truthful on their applications. With computers, checking up has been simplified, I would think.

Considerably. In the future with the federation once it gets fully computerized on all of these things, you will be able to find out all of this information that you can't find out now. Certainly, if we have found out that an applicant has attempted to deceive the Board, we've acted on it, and we have not accepted those applications, or we have revoked their licenses if we had previously given them. On a number of occasions, if we, in fact, really

feel that there was no attempt to deceive the Board, that it was done in relatively good faith, of course, we don't. But we have revoked several licenses on the basis of finding out in retrospect that they didn't tell us about certain things that occurred in other states.

There have been a number of significant changes in your years on the Board. But one of the issues of public concern is substance abuse with the physicians. What do you feel about that; do you think that the stresses have increased? Do you think that there is higher incidence of abuse or maybe more reporting of abuse? Do you think early treatment in handling it is decreasing the abuse?

Well, again I think the confidentiality which exists within the Physician's Aid Committee and the physician, permits the physician with the drug abuse, alcohol abuse to feel a little bit more comfortable about admitting the problem and getting some help. They're very fearful of the Board. The Board is not an advocate for them. We're an adversary, and everyone out here who has a license realizes what the power of the Board is; they're really . . . they're frankly afraid. If it had to go to the Board as opposed to a Physician's Aid Committee who cannot revoke their license, they are much more likely to admit their problem to a Physician's Aid Committee than they are if the Board called them.

This does mean in a sense that the Board has to turn the other way on occasion, because we know that there are a number of stipulated agreements between the Physician's Aid Committee and doctors who have substance abuse that are out there that the Board is not taking action on. However, to protect the public, we feel that by this early intervention, in the long run, it helps doctors become rehabilitated; and if that rehabilitative

process is violated, then the Physician's Aid Committee will come to the Board. And the Board then will take action.

We think that the earlier intervention, which is more palatable to the individual with substance abuse, works better as far as the public is concerned. It is beneficial to the public because things are picked up at this earlier stage. If we had to pick them up, there would be constant denial. So it would take longer and longer to prove, and they still would be out there in practice. So with these people we insist that the Physician's Aid Committee make an agreement with them indicating that if they violate that agreement, then the Physician's Aid Committee will come to the Board and so inform us. I think you are getting much earlier intervention. It does pose a problem because we know something's going on, but we have to look the other way, temporarily hoping that in the long run it helps the public. That's the only reason we do it. Not to protect them; not to have brother protect brother. But in the long run we feel it is beneficial to the public.

If they entered into a contract or an agreement with the Physician's Aid Committee, does that cover you legally? Because some informal action's being taken?

No, theoretically there still has not been any formal complaint against this individual which has come to our attention. Certainly, if it is something that comes to our attention — say, another doctor complains about this, or the hospital complains about it — then we're more likely to take action. Although even there we will sometimes have the Physician's Aid Committee talk to them initially, so that they're informed of what's going on and let them work it out. It still may be a considerable amount of time elapsing before we could act as a Board. Now, if things are so gross that it

does represent a threat to the public welfare, the Board can do a summary suspension immediately. And we've done it if it represents a threat to public safety.

Have there been times when the Board has restricted the type of medicine that a physician is practicing, entered into a formal agreement with the physician and his attorney?

Yes, we can impose any restrictions that we want, that we deem necessary.

Is that a useful tool?

Yes, it can be a useful tool, and we've used a lot of it in the past.

As medicine is entering a period where it could possibly change a great deal, do you think with things like managed health care and the HMOs, that the function of the Board is going to be complicated?

That remains to be seen, but, yes, it can. I think one of the major potential events that can occur is if under managed care the utilization review that's going on within that managed care says they won't authorize a diagnostic test. Let's say there's a test that the doctor feels should be done, and the managed care utilization says, "No, don't think it's warranted." That can create a tremendous liability as far as the physician goes. Obviously, he can always suggest that the patient still go ahead and do it at their own expense. But oftentimes, when it's not authorized, it makes it more difficult for the doctor to say, "Hey, I still want to go ahead with this test. And pay for it yourself."

"What do you mean pay for it myself? I can't spend a thousand dollars for an MRI, even though you think I should have it."

Well, just suppose that the physician says, "OK," but doesn't insist that the patient go ahead with it. Or doesn't get a signed document saying that he discussed it with the patient, and the patient refused to have it because it wasn't being authorized. If subsequently something does happen, that doctor's at tremendous liability for gross malpractice, even though there were some extenuating circumstances in that the managed care utilization felt that it shouldn't be done, that it was not a necessary test to do. Some of those decisions, a lot of those decisions, are not made by doctors; they are made by nurses and sometimes by individuals with lesser training than nurses. And it puts the doctor at financial liability and, also, potential license revocation or license restriction. Not because he didn't think it was necessary, but because the managed care organization thought that it shouldn't be authorized, because they're interested in cost containment. That's their primary focus.

So could this be the practice of medicine by bureaucracy? A clerk who says, "OK, these are guidelines; this particular case doesn't fit within those guidelines," so it's denied.

And there are a lot of cases that fall through the cracks, that don't fit into all guides. Guidelines are fine, and they will work a lot of the time, but you can't have guidelines for everything. It's medicine by recipe.

What do you think is the most significant change you have witnessed during your tenure on the Board of Medical Examiners?

Well, I think the biggest change is our disciplinary aggressiveness and the quality of the applicants in direct proportion to the fact that they've had to have at least a minimum

of three years training in this country and Canada in an approved residency. The increase in disciplinary aggressiveness I think is directly related to the personalities of the members of the Board, our legal representation, our strong statutes, and the expectation of the public.

Finally, your choice of medicine?

I've never really regretted it; I still enjoy it tremendously. I'm not happy with some of the recent occurrences that affect the medical profession. I'm cognizant of cost containment, I'm cognizant of the cost of health care, but I do resent the involvement that government and third parties have between the patient/doctor relationship. But I've never regretted being in the practice of medicine.

LARRY LESSLY

Larry Lessly was born in Denison, Texas, in 1942. He attended school there and went on to the University of North Texas, graduating cum laude in 1964, with a teaching degree in secondary education. He entered the air force and served as a captain for four years on active duty. He continued his military involvement in the air force reserve, and the Nevada Air National Guard until 1993, when he retired as a brigadier general. After leaving air force active duty in 1968, he entered law school at Southern Methodist University, receiving a J.D. in 1970.

Mr. Lessly came to Reno in 1970, and has practiced law since passing the Nevada bar in 1971. He has prosecuted for the Reno city attorney's office, practiced privately, as well as serving as vice-chancellor for legal affairs for the University of Nevada, Reno. His favorite area of practice is administrative law, and he has had a wide range of experience in that field. Mr. Lessly has been associated with the Board of Medical Examiners since 1983, and became their general counsel in 1992. In December, 1995, he became the Board's executive director.

Larry Lessly: My family's from a little town in northern Texas by the name of Denison. I was born there in 1942, went through all the public schooling there. My father worked for the Missouri-Kansas-Texas Railroad there in Denison; that was the corporate headquarters of that railroad. My grandfather worked for that same railroad. My mother was a housewife. She worked in a jewelry store at the time that I was in high school and in college. I have one brother who's about three or four years younger than me, and he still lives there. He's the operations director for the public transit system that operates in about four counties in the northern part of Texas.

After high school, I left there and went to college at an institution that was called North Texas State College when I started. It's now the University of North Texas. It's about eighty-five miles from Denison, fairly close to home. I graduated from there with a teaching certificate in 1964.

I entered the air force in 1964, was on active duty for a little over four years. The first couple of years I was stationed at Stead Air

Force Base here in Reno. My wife was teaching school, and we met a lot of schoolteachers. I always intended to teach school, and we thought that this would be the place that we would want to come back to and both be schoolteachers. Somewhere along the line I got the bug to go into law school, and that changed that game plan.

Anita Watson: What prompted that, do you know?

Yes. After Reno we went to Fairchild Air Force Base in Spokane, Washington. I was living in a duplex on the base in the officers' housing area. A couple lived in the other side of the duplex; he was a judge advocate, a lawyer for the air force. I don't even remember his name, but I do remember that I thought that if he could get through law school, anyone could.

[laughter] So you weren't motivated by somebody you looked up to? A role model you wanted to emulate?

No. I knew that I needed to go to graduate school. In the air force, if you're not pilot or a professional, you don't really have that great a career ahead of you. I had decided that since I was not a pilot and didn't have a professional degree, I was going to get out and go back to graduate school somewhere. Had toyed with the idea of going to seminary at Princeton and changed my mind about that. I started writing for some scholarships and decided law school was the place I wanted to go. Not primarily because I knew what I wanted to do, but because I thought the degree was probably more versatile, and something you could probably get into anything with.

Did you go to air force with the intention of making it a career?

I considered it, yes. Yes. Had thought that I might. I found you can make lieutenant colonel if you stay twenty years in the air force, but if you're not a professional person, a chaplain, or a judge advocate, or a medical officer, you don't really go beyond that. It's kind of a dead-end career, and you're probably not going to get to stay longer than twenty years. In my situation I figured that I would be forty-two years old and retired, with a twenty-year-old teaching certificate for English and history. That's not a great job market, nor a great age to be out looking for one! [laughter]

Got out of the air force in '68; went to law school at Southern Methodist University down in Dallas, Texas in the fall of '68, and graduated from there in December of 1970. We packed up and came back to Nevada at that time. I took a job as a law clerk for Judge Gabrielli, who was Department 3, the District Court at that time. I was his first lawyer law clerk. He had had bailiffs before who had not been law school graduates. I worked for him for about a little less than a year, right up until the time that the Nevada bar was offered.

In those days you had to establish residency in the state of Nevada in order to take the bar. That's not the case now. The bar was only offered once a year in Nevada, and that was in the month of September, I believe. Normally, you graduated from law school in May, and if you moved to Nevada then, you didn't have the six months' required residency in the state of Nevada to take the bar in September. I suppose that was the way that they kept a lot of out-of-state lawyers from coming in.

I went to a law school where you could go year round. I went year round, and graduated in two and a half years instead of in three. So I was out of law school in December, established residency in Nevada in January, and by the time I got to September, I was

ahead by six months. I worked for Judge Gabrielli for a little less than a year. I think I quit, probably, in June or so, studied for the bar a few weeks, and then took the bar exam.

I went to work for the Reno city attorney's office for Bob Van Wagoner, who was the city attorney at that time, as a prosecutor, and started prosecuting cases the afternoon that I was sworn into the bar. I worked there about a year, and I then went into private practice as an associate with a gentleman by the name of Harry Swanson, who was a very active divorce litigator in those days. I worked there for a couple years, but I just didn't really care for private practice too much, and decided I wanted to go back into some type of government work.

I went to work in the district attorney's office in the civil division. The chief deputy in those days was Chan Griswold, and Bob Rose was the DA. Bob Rose was elected lieutenant governor several months later, and Larry Hicks became the DA. I stayed in the DA's office for a couple years, and I got into administrative law, which is what led me to the medical board, I suppose. I represented the Board of County Commissioners, and I represented the Regional Street and Highway Commission, Truckee Meadows Fire Protection District — a lot of boards and a lot of administrative law. Did that for a couple years, liked that, but a job came along with the university, and I became the general counsel for the university system in 1976. Was there for about five years: worked for about three years as general counsel for the system, and then became the vice-chancellor for legal affairs for the system for a couple years.

I left there in '81 and went back into private practice; stayed in private practice until about two and a half years ago. During that private practice time I did mostly administrative law. I did a lot of labor law

in NLRB, Employee Management Relations Board, and worked with public employees here in Nevada. Did some general practice-type things, but still had a concentration in labor law and administrative law.

What is unique about administrative law versus other types?

Well, it's a lot less formal than the judicial system, the rules that are imposed by the judicial system. For instance, in our administrative hearings the rules of evidence don't really apply. There are a lot of things you can do with a lot more latitude in administrative law than you are able to do in a formal courtroom setting. It's just more relaxed.

Are you a little bit unusual in having jumped around to different things? That you were able to do what interested you?

Yes, I guess if I look back on it, I can say I've always been able to do that. If I wanted to do something else, I've always been able to stumble into it. Of course, I was considerably younger at that time! [laughter] It's a little harder to do as you become older. But, yes, and even today I've been able to leave my practice, because a substantial portion of my practice was with the Board even in private practice, and do what I want to do. This is the kind of law I want to practice. I like the administrative aspect of it, and I like the medical aspect of it.

So you had the background, and Dr. Scully told me he felt sorry for you, . . .

[laughter]

. . . picked you up off the street, and offered you a job.

I had known Dr. Scully. Dr. Scully had been the assistant dean, and then the acting dean, and then the dean for a period of time when I was general counsel with the university system. So I had known him. I represented the university with the Howard Hughes estate to get the \$200,000 a year that had been the seed money that the legislature had acted upon to create the four-year medical school program. So I had known Dr. Scully for some time; he did not feel sorry for me. [laughter]

I was trying a case in the Washoe County Courthouse one afternoon, and during a break I walked out in the hallway. Tom Scully was standing there and said, "What are you doing?"

I told him what I was doing, and I said, "What are you doing?"

He said, "I'm here testifying on a child abuse case." He said, "Let me ask you a question. I'm on the Board of Medical Examiners, and our attorney, Bryce Rhodes, has been our attorney for about thirty-seven years, and he's retiring. How would I go about finding someone who would be interested in being an attorney for the Board of Medical Examiners?"

Well, I'd been out in private practice a couple years, and I was really in the building process myself, so I gave Dr. Scully my business card, and I said, "The way you find someone to take that job is you call this number in about thirty minutes, and the guy who answers will talk to you about it."

So we talked, and I agreed to represent the Board on a couple of disciplinary cases on a case-by-case basis. Bryce Rhodes was still involved in it. I came over and did a couple of prosecutions for them, and it just sort of evolved. I became their primary attorney. The attorney general's office still is involved, and represents the Board in some disciplinary actions, and also has an attorney present at all

of our meetings. It just sort of evolved from there to the point that I signed a contract with them to continue doing their prosecution and general counsel work on a contract basis while still in private practice.

I think it was the latter part of '83 that I began to do that, and those cases lasted two or three months. At that point they said, "Why don't you just come do our legal work for us on contract?"

Is that different from being on a retainer?

Yes. I think, as I recall, I billed them based on an hourly rate for the cases that I did. Then when I went to work for them, I simply had a monthly — and I tell you the truth; I don't remember how much it was — but I had a monthly amount that they paid me. I told them that was a good guess as to how much time I would spend, and so they paid me that flat rate every month. I was required to do all of their work for that flat rate. And that went up a couple of times.

I remember they began to phase the attorney general out of the prosecution of the cases, and I took on more of that. That would have been about 1987. They raised the fee at that point and progressed from there.

The Board has that type of latitude?

Statute allows the Board to hire attorneys. They have traditionally and always, to my knowledge, had an attorney general involved, also. We have — we had, and still have, a division of effort between the general counsel for the Board, whether it had been Bryce Rhodes as a private practitioner, me as a private practitioner, or me as an employee of the Board status, and the attorney general's office.

The attorney general's office has always represented the Board in litigation that might

be, for instance, civil rights litigation, where there's the liability of the state of Nevada for the actions of Board members. We've divided those disciplinary matters so I would either prosecute one, or the attorney general would prosecute one, and then the other attorney would act as advisor to the Board. If I prosecuted the case, the deputy attorney general assigned would represent the Board. If the decision of the Board was appealed to a district court, since that's the attorney who represented the Board in reaching that decision, that attorney would go forward and defend the Board in district court on appeal, and vice versa. If I represented the Board, I would take the appeal. So we've always had that division, and we've always had two attorneys involved, from as far back as I can remember.

One of the trends over time for the Board is increasing complexity of the legal matters that the Board is involved with.

Yes. Yes, and I guess that was addressed back in 1985 with the revision to the statutes. First of all, the cases are always complicated because they're medical in nature — if they're patient care cases. We have a lot of cases that are not patient care cases. They're basic issues of impairment or dishonesty or attempt to defraud a patient. Or it might be an attempt to get a license by fraud, lying to us on an application about background in an effort to get a license. There are a number of non-patient-related issues that are subjects of disciplinary action. But with the basic case of patient care, there is always going to be a medical issue involved, which makes it complicated. You need assistance on those kinds of cases from expert witnesses, so it's always a case in which you have to work with expert witnesses, and you have to present

expert witness testimony for the Board to make a decision. So, yes, they're complicated.

In 1983, when I went to work, the way they were handled and a determination made as to filing a complaint was really real simple. Dr. Scully, or Ken Maclean before him, as the secretary; and the attorney, whoever that might be, whether it would be Bryce Rhodes or me or the attorney general; and the executive director would sit down on a Wednesday afternoon or a Tuesday afternoon, and decide that we needed to file a complaint against this physician. Then they would go to the Board and recommend to the Board that a complaint be filed.

That was changed in 1985 because of the growing number of cases and the complexity of the cases. Before 1985, the entire Board of the Medical Examiners would sit to hear a complaint. So a Board member had to commit to a lot of time per year. If you did a dozen cases in a year, and I guess that would be rather high, but if you even did a half dozen full-board cases in a year, that meant that that Board member, not only in addition to the time spent at the meetings and preparing for the meetings, would have to appear and sit to adjudicate a disciplinary action. In 1985, then, when we revised the Medical Practice Act, we changed the system to provide that you could use a hearing officer, or you could use a panel of three members of the Board, or you could have the full Board hear the case. That allowed the Board to take some of those cases that were not complex in nature, that might be based on an action taken in another state — for instance, some of the cases that didn't have the issue of credibility of witnesses — and shift those over to a hearing officer. The hearing officer would hear the case and do a synopsis of the testimony; and the Board would simply get the transcript of the testimony, read the testimony, read the synopsis by the hearing

officer, and then make a decision on the case. They didn't have to spend the four or five days that were necessary for the average case to adjudicate it. That was a major change to take care of a number of cases.

As far as complexity was concerned, it still let the Board read the transcript, and if there was a medical issue, they would make that determination on their own, based on reading the transcript. The growing complexity — obviously, as you get more and more technology, the cases that we have today are more and more complex, and they're closer calls because of the numerous ways you've got in treating a patient today for the same malady. I guess that's a long answer to your question: yes, they're getting more complex!

What's the background of the Open Meeting Law? It certainly has had an impact on the way the Board does business.

Correct. The basic philosophy and the legislation that resulted — the Open Meeting Law — was that government ought to be open and that the citizens of Nevada ought to know what their government is doing, ought to be able to appear and see what their government is doing. The legislature, in its wisdom, passed the Open Meeting Law, but didn't make it applicable to the legislature. So citizens in Nevada are entitled to know what their government is doing, but not their legislative branch of government. It's applicable to all the other branches of government with some exceptions. I believe the Gaming Control Board may have an exception about some confidential matters.

That's a real problem for the Board of Medical Examiners if you just say it's all open. There are a lot of things that the Board does with a physician that ought to remain confidential until a decision is made. Here's a

perfect example of it: if you simply go out and start investigating a physician, and the public has a right to be present when you're doing that investigation, there are a lot of things that don't need to be public. If a decision is made that there's no problem with that physician's conduct, but the process is public, the news media's already picked the fact up that he's under investigation. It hits the newspapers, and his practice is ruined. There may be absolutely no reason whatsoever to ever even anticipate that a complaint's going to be filed. So we had legislation which exempted the investigative aspects of the operation of the Board from the Open Meeting Law, and that was done in 1985. Almost lost it 1987 when the legislature got very concerned about impaired physicians.

That's another aspect of the Open Meeting Law, that the investigative committee deals with impaired physicians. By impaired physician, I mean someone who is a drug or alcohol abuser to the point that it's dangerous for that person to treat a patient in this state. We have a confidential way of handling that, all done by statute, and not subject to the Open Meeting Law.

The investigative committee signs a stipulation with that physician to put that physician into an after-care treatment program. As long as the physician is participating in that program, he's not impaired. As long as he does what he's supposed to under his contract with our Board and with the physician's assistance committee, we don't regard that physician as being impaired. He is in recovery, and he's not drinking or he's not using drugs. It's safe, so long as he does those things, to practice medicine. Well, those are obviously conditions that don't need to be discussed publicly. The person may have gone through a recovery program, may be perfectly safe to practice, but the simple fact that that

problem exists will ruin that physician for that information to become public. So those stipulations are confidential.

Nineteen eighty-seven had some changes that were made to the Medical Practice Act. The legislature — and I remember very clearly in committee — simply went berserk at the idea that we would have confidential stipulations. They thought that every citizen in the state of Nevada ought to know if their physician is a drunk or drug addict. They never understood the concept that they're not drunk or a drug addict who is dangerous if they're in a recovery program, and are participating in that program, and are making steady progress in it. It was questionable that we were going to get to keep the Open Meeting Law and the confidentiality provision on impaired physicians. Somehow, before the end of the session, it dropped by the wayside and has never been heard from again. Nor do we ever go to the legislature and mention it again. [laughter]

The whole idea of that type of information being made public — what was your justification for that? The first thing that comes to mind is that people aren't going to come forward with a problem if they think it's going to immediately be made public.

Yes. The physician who has the problem is not going to come forward. The other physicians in the state who know of the problem are not going to come forward and tell us about that physician with the problem. Without the confidentiality, the program would never work. That was our argument to the legislature; you have to have that confidentiality, or it'll all go underground. It'll be a self-preservation within the profession; we'll never hear about it. It'll never become public, and physicians won't go seek treatment

if they know that if we find out about that treatment, it would become public. So, yes, that was the justification. It deserves to be confidential because, first of all, the physician is not a danger if he's in the program and making progress in the program. Secondly, the program wouldn't work; it would all go underground.

We were one of the first who did that. Oregon had a good program going the time we did, but almost every state in the Union has followed the lead that we took in 1985 and has a program like that. Some of them have been confidential, and they now have come public in some states. It goes back and forth, depending on the political climate of the state, about whether it should be confidential or not.

Do you see a little bit of a problem with the legislators being involved in the creation of the Medical Practice Act? It's a little bit like the public members being on the Board. At some point there was criticism, and some physicians weren't really sure, "What are these people doing here? They don't understand medicine." I see similarities with the legislators. In particular, I'm thinking about the acupuncture issue. The Board objected to the legislators making these determinations, because they didn't have the medical background to do it.

Well, for instance in 1985, when we went down and made proposals for our complete revision of the Medical Practice Act, I don't think there was too much knowledge within the legislature about what that act was really about. The only thing I remember there being great controversy about was Laetrile and Gerovital. These were the two drugs that they wanted a specific exemption for, so that those physicians who practice what I will call nontraditional medicine in the state of Nevada would be allowed to prescribe those

drugs. They hauled all kinds of witnesses and people, patients in to support that. Our Board could have cared less, to begin with, but they made a big hullabaloo about that. The entire emphasis and interest on that bill — and it was a massive bill, a major reorganization — was on the Laetrile and Gero vital issues. I doubt very seriously that many of the other members of the legislature really understood that bill one way or the other. They knew they had to react to one emotional item, and they did react to it, and they put a provision in our act, which still exists today, that says it is not malpractice to prescribe those two substances.

So I don't know that there's been a great concern about the Board being concerned that the legislature doesn't understand. I guess it's no different than the public member appointments to the Board, and that happens all over the country in every profession, including mine — the legal profession. The public members we've had appointed have made a contribution, even though they're not — and can't be, by statute — involved in medicine. There are a lot of disciplinary things that happen and policies that are made that you don't have to have medical knowledge to participate in. For instance, the dishonesty, the ripping off of the patients financially — those kinds of things. The public members have been right up front, and have done a good job of representing the public that they were put there to represent on those kinds of issues.

The 1985 Medical Practice Act was the big legislative issue in the recent history of the Board. You were involved in that from the very beginning. Where was it coming from? What was the motivation?

Part of it, I believe, was the impaired physician aspect of it, an impaired physician

program. There was not one. I think our Board wanted there to be one, based on what was happening in a couple other states, the primary one being Oregon. Our act had not had any organized revisions — it had been piecemeal up until that time. There may have been some other revisions way back in years gone by, but basically what had happened was a statute was added piecemeal here and there to cover problems. You had a real hodgepodge-type piece of legislation, and there needed to be some revision as far as the number of Board members, to include additional public members on the Board.

It was really a major revision. A gentleman by the name of Kim Zeitland, an attorney, was hired from Washington, D.C. He had represented a number of boards in his career and back there. He was hired as a consultant. Ellen Whittemore, a deputy attorney general for the Board, and I reviewed his work when it came in. What the Board said was, "We want to completely revise the statutes; we want a modern act."

The Oregon act was one that we thought was a good act and would be good pattern. A lot of what had been adopted in Oregon is included in our statutes, including the investigative committee operation, the impaired physician committee, and the composition of the Board with public members. Oregon had a very modern act compared to other states, particularly in the West. We took that as a potential pattern and built from there.

Has the West tended to be a little slower legislatively?

I'd say they're a little faster legislatively. Arizona's act is very modern. Arizona has a very good operating impaired physicians program, even though they have now gone

public with their program. California has a diversion program; Oregon has a diversion program operated independently by their board.

What do you mean when you say “diversion”?

If you are a self-reporting physician who comes to the board with a drug problem, they will send you to their diversion program for evaluation. If you participate in that program, no disciplinary charges are filed against you if you successfully complete that program. We do the same thing, but without a formal diversionary program operating as a branch of the Board or independent of the Board. For instance, in Oregon the offices aren't even in the same location. In California, the same situation: they may report to the executive director of the board, but their offices are independent, different location, so they have complete confidentiality. We have the same basic program, but without the formality of the program being operated independently or in a separate location from the rest of the Board.

One of the important things with the 1985 act, as I understand, is a more formalized, disciplinary procedure with physicians. Can you explain how that changed?

Well, as we were talking earlier, the manner in which complaints were filed was sort of willy-nilly. Until the 1985 act the secretary, the executive director, and the attorney would determine that a complaint ought to be filed, and take it to the Board. With the 1985 act, it created the investigative committee. The act provided that one of the members of the investigative committee had to be one of the public members on the Board, so that at least one-third of the membership

committee was public and non-physician. That committee had to make a determination about whether formal action was warranted. They had to go to the Board, and recommend to the Board that, based upon an evaluation of the complaint, and a peer review that had been done on the problem, and maybe a talk with the physician — although that didn't happen very often — that that committee would recommend that a formal complaint be filed and disciplinary action occur. Then the entire Board . . . or the remaining members of the Board — not the entire Board — the members of the Board who did not serve on the investigative committee would adjudicate the complaint, or it would be sent to the hearing officer. Hearing officer's report would come back to the remaining members of the Board, and the complaint would be adjudicated. So it was very structured, compared to what it had been prior to 1985.

Do you think it had changed a bit — obviously, it must have — in 1977 with the Open Meeting Law?

Well, yes. The Open Meeting Law probably wasn't a big bugaboo for the Board in those earlier days, because when the complaint was filed, it was filed by the entire Board. The hearings were all public to begin with. It's only the issue of the investigative process that became confidential by statute and was excluded from the Open Meeting Law.

I suppose there could have been some problems; those are kind of before my days. But in any event, the hearing was going to be public. It was only the phase that you went through prior to the hearing that had to be excluded from the Open Meeting Law. Part of the problem, too, was that a physician would have no knowledge that a complaint was going to be filed, and suddenly the complaint is

filed and in the newspapers, and he's notified that there's an investigation going on. With the structure of the investigative committee requesting records from the physician and having a contact with the physician, that precluded a lot of the problems we had about public complaints being filed and the physician having absolutely no knowledge whatsoever.

You said, though, it's fairly rare for them to interview the physician or discuss that with the physician?

Sure. Well, for instance, right now, we probably have six hundred, round figure of six hundred, complaints a year that are processed by the office. The investigative committee, four or five times a year — they might talk to half a dozen physicians. Usually those cases can be closed with just a little bit more information from the physician. Seldom — and I can't give you a name off the top of my head now — do we call a physician in, have him explain it, and then file a complaint against him. Usually those cases in which complaints are filed are ones where peer review's done, or the personal professional knowledge of the members of the investigative committee is used. They say, "We obviously have a problem here; file the complaint."

Those cases where a physician is called in are usually the patient care issues where a little more information face to face with the physician is necessary, more ability to communicate than you can by letter writing back and forth. You solve the problem, or you find out there's not a problem, and you close the case. The other people who are called in to the committee and complaints are not filed — those are the ones called in with what Bryce Rhodes used to call the spirit of bravado. We don't have any jurisdiction

over your demeanor with your patients, but we're getting fifteen patients a month who are complaining that you gripe and shout and rant and rave, and are very uncourteous to your patients. We call you in to find out if there's something wrong with you. We don't have any jurisdiction at all to do that, but there are a lot of those people who are called in, and who are questioned about demeanor with their patients or interaction in the office with the patients. Well, obviously, there are no complaints filed in those cases, because there's no jurisdiction to file anything over them anyway.

So usually it's the patients' files that come to the committee; their cases are resolved and closed. It's with those who don't, and there's a clear violation based upon a peer review or the opinion of the investigative committees, that the complaints are filed.

How do the physicians respond to the spirit-of-bravado approach?

Well, some have come with lawyers who demand to know what you're investigating, and we say, "We don't really know; we're just investigating. We're trying to see if there's a problem here, and if there is, I suppose we'll tell you what the statute is before the meeting's over." There's always the possibility — one of the indicators of impairment is erratic and unusual behavior. You can always call that physician in and investigate the question as to whether or not he might be impaired. He might be a substance abuser, might have a psychological impairment. We have authority to take disciplinary action based on that kind of a problem, as well as substance abuse. So there's always the issue of the impairment with someone like that. Statutorily, though, we just don't cover bad manners.

Dr. Scully was referring to the fact when physicians are impaired, have some sort of substance abuse, they can go into a program. Might be one month to three months. One of things that strikes me about that is what a tremendous burden that is on the physician and family. Other members of the Board have said they'd go in the next day; they go in that night sometimes. They just get on an airplane and leave.

Sometimes that's exactly right.

The logistics of that, of walking away from a practice, just seem overwhelming.

Well, sure. But the flip side of that is if that physician is in that circumstance, then what we depend upon is the physician's assistance committee of the Medical Association, who are our consultants — and they're the experts — to tell us that this person cannot safely practice medicine. Now, if they make that determination and tell the physician, "You're going to Georgia to the Talbot tonight," or it's a Friday night and, "You're going to be there on Monday morning," that's telling us, as our professional consultants, that it's not safe for that physician to practice. So, sure, there's a tremendous burden, both financially and logistically, to do that.

But the flip side is if that physician is in his office, his or her office, on Monday morning practicing rather in the Talbot program, then our job is going down the tubes. We're supposed to take care of the health, safety and welfare of the citizens of Nevada. And we're allowing an impaired physician to practice medicine under those circumstances. I guess the attitude of the Board and the investigative committee is one of sympathy and concern for those problems. But the aspect of protection of the public pretty well overrides that, and

there's not very much sympathy about the guy who says, "Well, I can't afford to go, and I'm not going to go." Well, that guy's not going to practice medicine with this Board.

Can you stop him from practicing right then?

Sure. You file a complaint against him to allege that he's impaired. Part of the reason you'd make that allegation stick is you have a committee of the Medical Association who have said that he's impaired and needs to be off in treatment and can't safely practice medicine. We file a complaint against that physician, and then, under the provisions of the Administrative Practice Act in this state, you can do a summary suspension of his license right on the spot, based upon the necessity to protect the public health, safety and welfare. You can take his license there on the spot, and then set the hearing, and have him come in. We do that within sixty days.

You can also place restrictions on a practice.

Well, yes, you can. You can summarily suspend a portion of his practice. For instance, if his difficulty is that he does a willy-nilly procedure of prescribing controlled substances to patients without there being any necessity for those — in other words, he's selling scrip — you could do a summary suspension of his right to prescribe controlled substances, and still let him practice medicine if that's the only thing that is a problem. In the circumstance we were talking about earlier, where it's an impaired situation based on substance abuse, you don't want him practicing any kind of medicine. But there could be a circumstance where you would say, "You can't do surgery," or, "You can't prescribe controlled substances," and you'd still let the

physician be able to practice, but with that limitation.

You said “selling scrip”?

Yes. Prescriptions. That’s a physician who is Dr. Feel-Good. You go to that physician because you know that you can get controlled substances from him. He’s an easy touch who will write a prescription for you for a fee, or he may be outdated, or he may be duped by his patients. There are all kinds of reasons that happens. But, yes, that’s what we call writing scrip or selling scrip.

There was an announcement in the news this morning about a computer program that they’re going to institute to control controlled substances, so that you don’t have people bouncing from doctor to doctor.

That’s a big problem in this state. The doctor shoppers are the ones who put a lot of drugs on the street. If you can get a prescription from five different doctors, and it costs you twenty-five dollars for the prescription or for the office visit, or forty-five dollars or fifty dollars, whatever, you make more than that on the one prescription if you sell it pill by pill on the street. You’re supposed to tell your physician that you’re getting drugs from another physician when you go to see the doctor. That doesn’t happen a lot of times. A lot of guys are duped, and you find one patient who is a known drug addict or a known drug seller or a known drug abuser who goes and sees ten different doctors. Without the computer program and some kind of centralization, you’re not going to catch that guy.

Occasionally the Board has responded to federal investigation of physicians, and it’s almost always drug related.

Or Medicare, Medicaid related, yes.

So they’re defrauding the system?

Yes. We don’t really have any jurisdiction to say that we take disciplinary action against you because the federal government took disciplinary action against you. We have to look at what they took action against you for, and we’ll go look at the same cases that the federal agencies do in many cases, and may well take the same action — or take action based on the same cases against the physician.

But you’re right on the drug side. A lot of the DEA prosecutions — if a guy’s convicted of a felony with relationship to the use or sale of narcotics, then we certainly have the grounds to go after him, based upon the felony conviction and the underlying offense.

What about the Board’s investigation of an individual? Do you ever share your information with federal authorities?

Sure. That’s one of the provisions in the statute: our investigations are confidential, but we’re not precluded from sharing with federal agencies, state agencies, or any other agency licensing that physician. We frequently deal with the DEA; we deal with the pharmacy board, which has the right to issue the prescribing license to the physician; we deal with local law enforcement issues, such as unauthorized practice of medicine or drugs. Under state laws we deal with all kinds of law enforcement agencies.

Another big issue in 1985 change was the three-year postgraduate training requirement.

Right. At the time that the three-year postgraduate training was passed, that made Nevada the strictest state in the nation as far

as postgraduate educational requirements for licensure. That is still the strictest, although I think there may be several other states who have gone to that.

Prior to 1985, we required three years postgraduate of foreign medical graduates and one year of American or Canadian graduates. We now require exactly the same thing of foreign graduates and American and Canadian graduates, and it's still three years postgraduate.

A big argument was made that it was going to cut down on the number of physicians that Nevada would get, would hurt rural Nevada, would give us all kinds of problems with recruiting. At the time that the bill was passed in 1985, I think Dr. Scully had a lot of statistics about all of the residency programs that existed. Virtually anyone who was leaving medical school was going into a program that was three years or more in duration.

I think our statistics would show that it hasn't hurt rural Nevada; it hasn't hurt Nevada at all as far as recruiting physicians is concerned or by keeping a physician from coming to Nevada. There was a revision to that act, I believe, in 1987 or 1989 — can't remember which — which allowed a county commission in a rural county to petition the Board to waive the three-year requirement, and take a physician with only one year of postgraduate education. Practice, however, was restricted to that under-served area of that county.

I suppose since that bill has passed, we may have had less than a dozen applicants from the entire state of Nevada. We recently had one from Incline Village, which has been declared medically under-served. But in my tenure with the Board, I couldn't name you six instances where that's been the case that we've had those kinds of petitions.

A couple of times you've had a petition for a medically under-served designation for Reno, for a specific specialty.

Right. In a specific area. That's different than the under-served area of a county. When a physician goes to an under-served area of the county, he's restricted to practice in that under-served area of the county. Can't practice anywhere else. If he stays there three years, then he can practice anywhere; he can get an unrestricted license in the state.

The designation of under-served in a specific area of practice is reserved to the Board, as far as the entire state's concerned. That's in order to give a temporary license to a physician who needs to practice in neurosurgery or whatever in a specific area of the state where they may not have that type of service available, or the service is inadequate. The Board makes that determination.

You said Nevada has one of the strictest requirements as far as the three-year postgraduate. Yet Nevada also has an impression — an image, if you will — of being wide open. There's been criticism of things like Laetrile and Gerovital within the medical community. Do you see any kind of — why don't we say contradiction — between the image of Nevada versus the reality?

Oh, sure. I think Nevada will continue to have that reputation of being a wide-open place to go. A lot of physicians still haven't gotten the word, and will come applying for licensure in the state with conviction or loss of a license in another state for sexual abuse of patients. They'll come to Nevada applying, because the reputation of this state has always been this is where you go. You get in trouble, and you run, and you can run to Nevada. Well, that pretty well got stopped in 1985 with

the law as far as the three-year postgraduate requirement. A lot of physicians who had been practicing for a great deal of time, and had gotten in trouble, couldn't meet that requirement. That cut down on some of it, but the legislature in this state has in effect sanctioned, "Any kind of practice that you can come up with in the field of medicine, you can do it in Nevada!" We have naturopaths; we have homeopaths; we have acupuncturists. You name it, we've had it.

The only group that I know that's lost the right to practice has been the naturopaths. They had an act governing them with a board, and the legislature wiped it out, took it off the books, several years ago. The idea, as I understand it, when it was repealed, was: we're going to stop the practice of naturopathy in the state of Nevada. Rather than outlaw it, they simply repealed the board that governed it and regulated it. Arguably, you might have the right to do something in the field of naturopathy in the state of Nevada, or you might not, depending on what the courts would say about what the effect of that repeal of that legislation was.

We still have other, what I will call nontraditional practices in this state that have been sanctioned by the legislature. The attitude's always been that Nevadans ought to get to pick what they want in the field of medicine as far as a type of treatment for any kind of ailment they have with any kind of modality. I don't know that that'll ever change.

Legislators in the hearings for the homeopaths gave testimony as to how much homeopathic medicine had done for their mother-in-law or their cousin, or, "It cured me, and I feel a lot better, and so I think we should have it."

The difficulty with that law is that, you know, you have to be an M.D. to be a

homeopath, but you don't have to be licensed as an M.D. in the state of Nevada. You can be licensed in China; you can be licensed in Iran; you can be licensed in Mexico, or you might be licensed in Texas. As long as you have a license somewhere as an M.D., and have had the training in homeopathy, you can come to Nevada and practice homeopathy under the auspices of the homeopathic medical examiners. In Europe it's a well-known profession, probably more widely known there than it is here — very respected. I'm not saying that there's not merit to what they do here, but the legislature simply reacted to the desire to allow homeopathy in the state of Nevada, and just did it. We were one of the — I can't tell you the number — I think there might be two or three other states who license homeopathy in the United States, other than us.

There's been mention made of a compilation of the boards — they refer to it as an umbrella organization — that would bring the various boards together. Generally, the physicians have been against it. What do you think about it? Is it workable and feasible, desirable?

I doubt that it is in this state. That's just more bureaucracy. In Nevada no board that I'm aware of, no licensing board, operates with any kind of state funds. We all are self-funded, and our funds are generated by the fees that are charged the licensees. Every dollar that the Nevada Board of Medical Examiners operates off of is self-generated through the physicians. We don't get one dime from the state of Nevada.

A couple of things happen when umbrella agencies are created. One is you have a new layer of bureaucracy to do the same thing that the existing board is doing at no expense to the public. The second is that the legislature

captures your funds, and may or may not appropriate all or part of those funds back to you to operate. That's happened in a number of states where the fees that are charged the licensees. For instance, you charge a physician five hundred dollars for licensure for a two-year period or one-year period, whatever, and you appropriate four hundred dollars of that money back to the Board to operate on, and keep a hundred dollars in the general fund of the state. I don't think the licensees in this state are going to look at that very favorably, because some type of legislative funding would have to occur for an umbrella agency, or the fees would have to be increased of all licensees in the medical field in order to generate the additional funds to operate an umbrella agency.

The fees vary a great deal, don't they?

They go from almost nothing to our fees. We've reduced our fees in the last couple years, but basically \$350 to \$400 for a biennium for a licensure.

How many physicians are licensed in Nevada?

We have twenty-five hundred physicians active, probably, in the state and that number is increasing every day. There are a couple thousand maybe retired or inactive, not practicing in Nevada. Probably around four thousand or better altogether.

Were you ever active in the examination process?

What do you mean by active? [laughter]

Were you there for the examination?

I'm always there. When they did the exams, the oral exams that we used to

do, yes. For a period of time we had specialists in that particular applicant's field act as a consultant to the Board. They would conduct an oral examination of the candidate. If the consultants felt the candidate had not passed, they would tell the Board. The Board would then conduct its own examination or full-board discussion with the applicant. We always had at least one attorney present to advise the Board in those cases. So, yes, I've been present in every oral examination that's been conducted by the Board since 1983.

To advise the Board, not the applicant?

Don't have anything to do with questioning the applicant. I have sat in a few examinations and listened to them. Could probably almost pass one, but [laughter] not involved in any discussion with the applicant — strictly to advise the Board.

Your function is to advise the Board, and give them legal counsel. The Board's function is to protect the public interest; that's not necessarily your function?

My function is to help the Board do its job. Its job is to determine whether grounds exist to deny licensure to a physician in the circumstance we're talking about with an examination, or for what the licensure can be denied, and what is the procedure to handle that, and how should we proceed once we've examined the candidate. I simply am telling them what the statute says nine times out of ten. My function is to be there to simply tell them what they can or can't do from a legal standpoint. They make those professional determinations as to whether or not that candidate is qualified to practice. I don't get involved in that at all.

It seems that one of the trends I've seen is an increasing appeal process. Where do you think that's coming from?

I don't know that it's increasing. I think the potential has always been there. Doctors always hire or have a capability of hiring good lawyers. Doctors are not very prone to want to give up their profession when the Board tells them to. You can understand that there usually is a fight if we have a serious sanction imposed upon a physician. The procedure that we have right now of appellate process to the district court, followed by an appeal to the Supreme Court, has always been there. It's those sanctions which are serious that impact very severely on the practice or put the physician out of practice, that are usually the ones that go forward in appeal. So I guess in answer to your question, if there's any reason that there are more appeals, I would guess that it would be that the Board is taking more serious sanctions against physicians in an effort to protect the public. So you're going to get more appeals.

Did they increase their disciplinary activity based on this 1985 law?

I don't know that it's an increase in the activity. The number of cases that we have is fairly stabilized in the last few years at about six hundred. But there is an attitude on the part of the Board that they're not going to condone serious violations. They're going to take the corrective action that's necessary to correct the problem. That may sometimes put a physician out of practice, or it may severely restrict his practice.

Where do you think this attitude is coming from on the Board — this shift in attitude?

Well, I've worked for a lot of different boards in my career in Nevada. I'd say that this one is probably more prone to take its job very, very seriously, as opposed to other boards. I am not knocking any others that I know of, but the members of the Board are very concerned and very proud of their position on the Board. They're very concerned about the medical profession and also the public's impression of the medical profession. Part of it is probably because of a public awareness that you can do something about a doctor who is out of line, or who may not have treated you correctly, or who may have abused you. There's more and more awareness nationwide about that. So I would think that puts some political pressure from the public on the backs of the Board members to do something about it. Plus, I just think the Board has a very serious attitude about violations, particularly those violations that are abusive of patients.

Do you see the impact of personalities on the Board?

Oh, to a lesser extent than you might think. There may be some impact from personalities on certain issues, but generally when you get to the disciplinary issues, you see pretty standard professionalism by all of them. I can't tell you a case that I can think of where any political favoritism or personal knowledge was apparent. First of all, the Board members would step out of those kinds of situations if it were direct conflict, but they're pretty stringent and strong in their approach to each other, to the members of the profession.

You have had some Board members — Ken Maclean, Les Moren — in the past, even Dr. Jacobs and Dr. Scully more recently, who have been involved with the Board for so long. Now

they have term limitations. Do you think that's going to affect the Board?

Well, Ted Jacobs has been on the Board for a long time; Tom Scully has been on the Board for a long time. They all have a lot of corporate knowledge about the Board. You're not going to see anyone spend more than eight years on this Board from now on. Maybe only four years if the governor didn't reappoint the person. They could serve two full terms if the governor reappoints.

I don't know that it's going to have any impact. I think the Board has a good reputation in Nevada as being a Board that will take serious action against a physician. I think that anyone who would seek appointment to this Board would understand what he or she is stepping into, and would either have that same attitude or would certainly develop one [laughter] very quickly after serving as a Board member. I don't think that it's going to have any difference.

I think some people might tell you the change is good, will give them more opportunity for participation. But it takes a long time to become a good Board member. And, you know, the unfortunate thing is we see a lot of Board members who have gone off of the Board — Dick Baker, Ike Khan — a number of others who have served — Eva Simmons, a public member; Leo Wilner, a public member — who at the end of their term of office were excellent Board members. But you lose that corporate knowledge, and you lose that ability to deal with those kind of cases, and you start retraining someone again. From that standpoint, it never really bothered me that someone would serve twenty years on the Board, as long as they were a good Board member. But I doubt that it's going to make a big change in the quality of appointees. Doubt it very seriously.

LESLIE MOREN, M.D.

Dr. Leslie Moren was born in 1914 in Webster, Wisconsin. He graduated from high school in 1930 and completed his undergraduate work and medical school at the University of Minnesota, graduating with an M.D. in 1937. He served a one-year internship at Anker Hospital in St. Paul, Minnesota.

Dr. Moren practiced in Elko, Nevada, from 1938 until 1940, when he returned to Minnesota. He went into the military in 1942, and returned to Elko after WWII where he practiced full time until 1985. He was a member of the Board of Medical Examiners from 1950 until 1977, and was active in Nevada medical politics.

Dr. Moren died in his home in Elko, in December, 1994.

Leslie Moren, M.D.: I was born in Webster, Wisconsin; went to grammar school there and then to high school in Frederic, Wisconsin. My dad was in the hardware business, and he bought a hardware store in St. Paul, Minnesota, in 1930. We moved to St. Paul after I graduated from high school in 1930.

I think perhaps my role model was Dr. Arveson in Frederic, Wisconsin. About the time I was a sophomore in high school I decided I wanted to go to medical school. So I went to medical school — I went to the University of Minnesota and took a botched-together program: three years of pre-med, four years of medical school, and one year internship. I interned at Anker Hospital in St. Paul.

The last couple of years in medical school I worked as a junior intern in a pilot hospital, Mounds Park Hospital in St. Paul. I got fifteen dollars a month and my board and room. Fifteen dollars a month just paid the street car fare to go from the hospital to the university. I got off at the city limits between St. Paul and Minneapolis, and walked the last four miles to and from school. While I was there, Dr. Roantree from Elko brought his wife to that hospital. She was there for, I think, perhaps a couple of months. I'd go down and visit her.

After I finished my internship, I was planning to go over and take an option on

an office in Mondovi, Wisconsin. I had a letter from Dr. Roantree, and he invited me to come to Elko. He said, "Look us over. We'll buy you a round trip ticket under no obligation whatever." Well, I'd never been west of Jamestown, North Dakota. So that's how I came to Elko. Came here then in 1938, got my license in August of 1938, and worked for Drs. Hood, Roantree and Secor until 1940. That year I went back to St. Paul, and opened my own office. I practically starved to death.

Anita Watson: Why did you go back to St. Paul?

Well, because the doctors didn't want me to become partners with them. They wanted to be employer/employee, and I didn't want to stay that way all the time. So I left to go back to St. Paul, and saw my first patient on October 3, 1940. October, November and December my gross income for the three months was two hundred and two bucks, which didn't pay very much. [laughter] Then the war came along. I went in the military on April 15, 1942, and ended up in Italy. While I was there my wife and our two children, Ann and Allen, had moved to Elko.

I used to write to Laurena, my wife, that after the war was over, I'd come to Elko, and the world could go right by my front door. I wouldn't even thumb my nose at them; I wanted to be back in Elko. I missed it very much. Laurena was a native of here. In Minnesota it's pretty, it's green; they've got rivers and lakes, and people drown in them, but you can't see. Trees make the horizon just a couple of blocks away, you know. So I opened my own office in February of 1946.

On January 1, 1948, we started the Elko Clinic. There were four of us: Dr. Roantree, Dr. George Collett, and Dr. Dale Hadfield and I started it. And it is still in existence. Now they call it the Elko Regional Medical Center.

Why did you start the Elko Clinic?

Well, we'd started visiting, the four of us, and felt that the specialty approach to the practice of medicine could survive even in a small town, and we became enamored of the idea. That's how we started the clinic. Dr. Tom Hood came in 1948 for a while, and then he went back to finish his residency in surgery in San Francisco before he came back to the clinic in 1951.

Dr. John Read joined us. We had the first internist in this part of the state who could read electrocardiograms. He retired about ten years ago and died last year.

The first six months that we started the clinic none of the four of us could draw any money. We didn't have any money, accounts receivable, or anything to pay. We rented the ground floor of a building on Idaho Street, 946 Idaho. Galen Bell had built the building. We moved in, and the other doctors working for the previous group were smart. They didn't plan to move on January second, but I did and stepped over carpenters and electricians and plumbers and all. It was winter, and as they built the building, the beams between the first and second floors would freeze and crack like rifle shots. Scared the daylight out of me.

But it was really a good experience. The four of us formed a partnership, and we didn't even sign a paper for a year; complete trust. You know, that's the way it was. That was the way Elko was at that time, too.

What do you think was unique about practicing medicine in this area?

Variety. I think what was unique was the variety of cases that you'd see. Variety of people. Many with little formal education, particularly those that come from Basque

land. Those were sharp people, intelligent, for the most part, honest and hard-working, trustworthy people. You find exceptions to that, too, in every group.

We used to see cases of Rocky Mountain spotted fever, but we haven't seen one for a long time. Chloromycetin was the first drug that would treat Rocky Mountain spotted fever. When it first came out, Dr. Secor said, "Gosh I hope we have a case of Rocky Mountain spotted fever." We had two of them within a week.

Prior to that time they'd be in the hospital for two to four weeks. They couldn't work all summer. With the new drug, both of the patients went home in five days, and both went back to work in two weeks. One of them lived up in Montello, and he said, "Gee, Doc, those pills are fifty bucks."

I said, "If every fifty bucks you spent got you back to work faster — you'd be a rich man!" [laughter]

He said, "OK." But it's that type of variety that adds the spice of life, really.

Can you tell me about some of the people that you've worked with? About some of the changes that you've seen over your years in medicine?

Dr. Secor, who had gone to Marquette University, had been in World War I over in France. He was a roly-poly man. He'd have a belly laugh pretty nearly every day. He was just a wonderful man, a good human being. He never kept any records. He'd say, "Well, I took a blood test on this patient maybe two years ago, and it was such and so." He remembered. If I didn't write it down, I couldn't remember it worth a nickel.

Dr. Secor never had any children, but he helped children get into college financially. Some of them never even said "Thank you." He lived to be nearly a hundred, I think. He

died about 1955, the same year that Dr. Hood's dad died, 1955.

Did Dr. Hood tell you about his dad having the first X-ray machine in this part of the state? He got X-ray burns on his hands, and lost a finger because of cancer from X-ray burns. And probably had bladder cancer caused by X-ray exposure. He didn't know what exposure meant. Scatter ray.

The changes? Anesthesia. How much that has changed in medicine! Tom Hood's dad would get on the train and go down to Palisade, then Eureka, and do an appendectomy on the kitchen table with a kerosene lamp and chloroform anesthesia. Chloroform is not explosive, but ether is. He'd take the train back to Palisade; then they'd pick him up and take him to Elko.

Did you ever do any medicine like that?

Well, no. I'm not a surgeon, although I've had to do some surgery on occasion because nobody else was available at the time. But we've had interesting things — flew in an airplane a few times. I don't fly; I'm not a pilot. But one time they had to fly me out to Ruby Valley in a plane equipped with skis. We couldn't get off the ground when I'd seen the patient. My butt was too heavy to get the plane up, so the pilot kicked me out. He didn't want to go over the hill after dark, and I went back to the ranch house. I waited there until the snow plow came through. It took me into Wells, and I took the bus home from Wells. [laughter]

One time I got a call from a ranch. A boy from the military was home. He had just gotten out of the hospital with pneumonia and was not well. It was up in the Jarbidge country, I think. Couldn't get in there except by going through Idaho, so they flew me in, and were going to have a big bonfire in the field. When

we got there, I couldn't see any bonfire, but the pilot saw about as much smoke as coming from a cigarette. We landed in this field, and I got off. They put me on a horse, wound me down the canyon, and gave me a pot of beans.

When it was time to go, I got on the plane, and the pilot said, "Well, we're going to have to bounce this plane to get off." I didn't know what he meant. He hauled it over to the fence line, and pushed the plane and took off. We got up a little bit, and, finally, when we got to the end of the field, we were going around. I swore I could have picked the willows off with my fingers!

I remember one man with a back injury up north someplace. There was a field we were supposed to be able to land in. The pilot said, "We can't land there. It's in a box canyon." No way to get out, you know. So we landed over in a different field, and they came over. The man had a broken back. We put him on a Bradford Frame, and we sent him down to San Francisco to orthopedic specialists. And it was about two years they sent the frame back, and we had to pay for it. [laughter] The hospital only had that one.

I think the nursing profession has changed. When I came to Elko, the nurses got ninety dollars a month working a seventy-two hour week. They had board and room, and that's not very much money. I haven't any idea what they make now, but certainly they can't get by on that kind of income. They were dedicated women; there were very few male nurses in those days. Miss Herbster, who was the superintendent of the Elko Hospital when I came, was a nurse. Not a very good-looking lady, but the kindest person in the world. She didn't have a lot of formal education, but she had a lot of common sense. She's the only one that could fix the elevator when it went haywire. The only one that could take care of the furnace when it went haywire. The only

one that would mow the lawn. And she was a mother confessor for all the nurses, you know, a wonderful person. She went back to Iowa after she retired, and died back there. She did the Elko Hospital a great service; tremendous service.

Educational goals in the paramedical profession — nursing is an example — have changed a little bit. The educational process has changed, also. With the use of computers, visual aids, and so on — we didn't have those, you know, sixty years ago.

I think that the biggest change has been the physician attitude toward patients, toward people, perhaps. One of the reasons I was glad to join a group was because I didn't have to worry about the finances. I didn't know who paid or didn't, and could care less. That was the front office job.

We were led to understand that money was not a goal in the practice of medicine. We all thought that if you practiced and worked hard, you could get an honest living, but you couldn't become a millionaire practicing medicine. I think that generally was true. You could become a millionaire with investments; there are some that do. But that wasn't the primary goal.

The availability of transportation for seriously ill or injured patients is a big change. The only transportation we had was the train when I first came to Elko. You couldn't get them in an ordinary sleeping car because you had to go up the stairs and make a right-angle turn. With a stretcher you couldn't do it. We sent patients going in the mail car, because you've got a wide door on the side that you could get a stretcher through. Now you can get private planes or commercial airlines, and get any place you want in a short time. It wasn't so then. Because communication was difficult, or less easy than it is now, sometimes you just had a dickens of a time getting help even on the phone from somebody else, you know.

Our laboratory technicians were nothing compared to what we have available now. And the laboratory aides . . . the additional microscopes which are better, but you have also got the computer-assisted laboratory testing, which you never heard of, of course. That makes laboratory results available more quickly.

We haven't had a case of rheumatic fever in Elko in I don't know how long, ten or fifteen years maybe. It used to be common. Sulfanilamide was the first anti-bacterial. It wasn't antibiotic but anti-bacterial. Prontosil was an injectable dye; it was a sulfanilamide, a red dye. You just spill a drop on the sheet of the bed, and it's in there forever, never get rid of it. But it was the first drug that would prevent bacterial growth. When I was an intern, it became available, and we used it for pneumonia. Pneumonias carried a high mortality rate. They had about sixty different types of pneumonia.

The availability of specific drugs for specific purposes, of course, has just exploded. Penicillin first became available right after World War II. We had it in Italy during the war at the hospitals there. Injected ten thousand units every three hours; it hurt like a son of a gun. Now you give 2.4 million units in one shot, you know. This has been a boon to medical care as far as people are concerned.

There has been considerable written about unnecessary use of antibiotics, and that may be so, but I'll tell you the pressure on physicians to do something when patients are ill is great. At least you've got to give the appearance that you're doing something.

The use of blood transfusions — blood types were discovered early 1937, but the Rh Factor wasn't discovered until 1940. Now it's an important part before you give any blood transfusions. My mother had repeat surgery for gallbladder, and she had

twenty transfusions. That was before Rh was discovered. I'm Rh negative, and, of course, I gave her blood, but if she was an Rh negative and had gotten Rh positive blood, it would have killed her. We didn't know about it at that time.

The qualifications of laboratory technicians, the training of laboratory technicians, the training of X-ray technicians is much improved. And, of course, the equipment they've got to work with is much improved. The cat scan, the MRIs, ultra sound, and so on — undreamed of! And perhaps over utilized in some areas, and under utilized in others.

The things that dentists can do now is so much more than they could fifty years ago. That means saving teeth and currently implanting false teeth, you know. And schools of dentistry are tough schools. They really work your socks off if you are going to go to dental school.

I still think veterinarians have got to be much the smarter people in the world. How they can make the diagnosis and treatment plan so quickly on dumb animals is beyond my ken. And veterinary schools are hard to get into; they have a waiting list, too.

It's hard to convey to young medical students now how much more available is to them than was available to my generation. Knowledge, the acquisition of knowledge, the ease with which things can be done, surgical procedures that weren't even thought of, you know.

The University of Nevada, I think, accepts fifty-two medical students per year, freshmen medics. Last year they had over nine hundred applicants.

Have you been involved with the medical school?

Not for quite some time. We worked like the dickens to get it established. At that time there was a big north/south fight, Vegas/Reno. The thing that swung it in favor of Reno was that they already had a good department of basic sciences and a good library, which Vegas didn't have. But the school utilizes the Las Vegas facilities now very well, and if there is any internecine warfare, north/south, I haven't heard of it recently.

It's been a boon to Nevada. Prior to the medical school, there weren't more than about a dozen Nevada students in medical education. The medical school made a big difference for the availability of Nevada residents to get into medical school.

How did you become involved with the Board of Medical Examiners?

In 1950 Dr. Roantree died. He had been on the Board of Medical Examiners, and I was appointed by Vail Pittman to replace him on the Board. That's how I got started on the State Board of Medical Examiners. I was appointed by Charlie Russell, Grant Sawyer, Paul Laxalt; could have been Bob List in there? I can't remember . . .

O'Callaghan?

O'Callaghan appointed me one term; he did not re-appoint me in 1977.

Why did you want to be on the Board? Or why did you accept the appointments?

Well, it was interesting. We met four times a year, February, May, August, and November, I think. I think we got our transportation, maybe twenty-five dollars a day, when we would sit on the Board.

Do you remember going before the Board?

Back in 1938, yeah. Dr. Roantree was on the Board. I think we met at the Hot Springs down there at that time. Dr. Roantree and his wife and son and I were in the car, a LaSalle, I think. We came to a place by Oreana. It was a detour, and the sign said thirty miles an hour speed limit. Bob Roantree, his son, and I were sitting in the back seat. He said, "Dad, I don't see you going thirty; you are going eighty miles an hour." And he was. [laughter] But, because Dr. Roantree was on the Board, Dr. Creveling, who was secretary, said, "If you're going with Dr. Roantree, that's good enough; here's your license." They felt I'd been screened by Dr. Roantree enough, in effect.

I can't remember when Dr. Frolich was on the Board — after I came or when I was on; I can't remember. Dr. Stan Hardy was on the Board from Las Vegas; Dick Grundy from Carson. I can't remember the dates when they were on the Board.

Kenneth Maclean, all one word, a surgeon in Reno, went on the Board in November of 1949. So he was on when I came on, and he was on when I left the Board. He died a few years ago. He became the official secretary of the Board because he was in Reno and could get to the office for repeated deals.

At the time I was on the Board, we had a basic science board. Applicants for licensure for M.D.'s in Nevada had to have a basic science license.

What was the reasoning behind it? 1950 or 1951 is when the basic science law came in.

It was about then. I've forgotten exactly when. Well, basically chiropractors couldn't pass the basic science exam.

What did the basic science exam consist of?

Oh, the basic sciences: anatomy, pathology, physiology, chemistry — I can't remember all the subjects. It was a screening exam before they could take an exam for licensure.

Was it pretty difficult?

Yes. Basic science exam — you had to know those subjects fairly well in order to pass the exam. The State Board of Medical Examiners did not run the basic science exam. It was run by the University of Nevada. They put together that exam, and it served as a filter to prevent applicants, probably unsuitable, from applying for licensure.

I think when I was on the Board, a person had to be a graduate of a Class A medical school in the United States or Canada to apply. We had one applicant who wanted to go to a small town that wanted him, but he had gone to a medical school that was never accredited, and you just couldn't give him an exam. He was furious. He got the townspeople angry at the Board for not letting him in.

The law was set up so that the State Board of Medical Examiners had the authority to discipline physicians, up to and including revocation of licensure. I remember the first one that we revoked license on was a doctor who was convicted in Washoe District Court of doing illegal abortions. Under our law conviction of felony was prima facie evidence of unprofessional conduct. We revoked his license on that basis. His attorney took it to the Supreme Court, and wanted to stay that revocation. The Supreme Court said not only do we have the right, but we have the duty to go after conviction of felony. That strengthened the hand of the State Board of Medical Examiners in that respect.

We've had a few revocations. I think that was the only one for doing abortions. That particular physician had a contact man down at the University of California at Berkeley for pregnant girls to come up here and get abortions. The income tax people were after him because he bought two new automobiles, and paid cash for each of them in the same year. [laughter] And reported a total income of six thousand bucks or something like that!

We didn't have any money, but we did not get state money. One time some of the legislators wanted to put us under the state government. We fought it because we felt that would tie our hands politically.

There was never any politics heading the Board. I think I was on for quite a long time before I found out I was the only one of the Board members that was registered Republican; all the others were Democrats. It never came up on the Board.

We didn't have information from the other state licensing boards that they now have. They're all computerized, and if a physician applies for license, they check off his name because he has been disciplined or had hearings or whatever. They can find that out. We didn't have that at that time. I think our license fee was ten dollars a year, and now I think it's three hundred and fifty dollars for a two-year license.

We tried to check as near as we could on applicants for license. Evelyn Hilsabeck, the secretary, would pick up a directory and call a doctor in the city where a physician was applying from to see if you could get any information. It was almost impossible to have people write derogatory information about applicants because of the freedom of information.

And concern about lawsuits and slander?

You bet, and defamation of character and so on. There was one doctor from California, Southern California. Mrs. Hilsabeck called somebody down there, and they told her, "Check with the California State Board of Medical Examiners." Found out that this man was charged with practicing medicine without a license in California. He employed several doctors and hadn't paid them. He had three cars on lease, a BMW, a Jaguar, and a Cadillac, I think at the same time, and was behind in the rent. We had this information. We couldn't let him know where we had gotten it, or exactly what the information was. He said, "Well, I can get that all fixed up."

We said, "Well, fine. We won't give you a license now. We'll meet again in three months. Come back then." He never did come back. That was pretty well documented to our satisfaction. Now the applicant's name is punched through a computer and goes all over the nation, the Federation of State Medical Boards. They've done a good job in that respect.

When you consider taking a man's license away then you're basically taking away his livelihood. It's a serious business.

Taking away his livelihood. In the public eye you're condemning him. In our hearings Bryce Rhodes was there. They are quasi-legal, but they're not like a district court. In every large group you've got some bad apples. You know that! Doctors and everybody else. But the percentages are not too great. But those that proved to be bad apples, sometimes it's hard to get rid of them. Hard to prove that they are.

Actually over the years there weren't too many revocations of licenses. Nowadays they are better able to get it because of the computer hookups with the other licensing

boards in the nation. If an applicant falsifies his application, they will be able to check on it pretty well, you know. And right now, computer quick.

We had one doctor who came from another state, and he checked out OK; had good recommendations. But the Clark County Medical Society wouldn't admit him to membership. They did more checking, and could get what we couldn't. They were mad at the Board for giving him a license. That happened a couple of times in Clark County. They were vigorous in trying to find out the backgrounds of physicians who were trying to join the Clark County Medical Society. Because that was sort of a status symbol once you joined the County Medical Society, and in that way the State Medical Society.

What about discipline for physicians then? That's certainly one of the functions of the Board.

I think that physicians have to answer to a higher level of conduct than non-physicians. I think the profession demands it of them, that their conduct be exemplary, above reproach. Failure to live up to that code denigrates that person and the profession. Obviously, it's not observed 100 percent, but probably by a fairly good majority. I think that feeling exists. A fairly good majority of physicians feel that, "I owe it to my profession to do the best I can." And failing that our conscience should raise Cain.

It was during your tenure on the Board that they added to the questionnaire whether or not any physician had ever been charged or been convicted of a morals charge.

Yes, moral turpitude, felony, or alcohol or drug abuse or whatever. I can't remember

the name of the doctor down in Texas who was working hard to get all the state licensing boards in a network so we could get information about applicants.

Then in the early 1950s we had the problem with accrediting foreign medical schools. Of course, our law had not permitted that. Some of the schools you couldn't get information about. Others you knew were just bad. We held a three-day meeting down in Las Vegas to help write a law permitting us to examine candidates from foreign medical schools. Bryce Rhodes, our attorney, was there at the meeting. We spent three days trying to hammer it out.

It's a good thing we did, because in the next legislature, one of the legislators had a bill all ready to be introduced giving carte blanche permission for a graduate from foreign medical schools to come in. Well, that didn't suit what we thought was right because some of the foreign medical schools, even in Mexico and in the South American areas, were not really good medical schools. In other words, they wouldn't come up to the standards of the U.S. medical schools or Canadian medical schools.

Where was this legislation coming from that somebody was lobbying for this?

I don't know. But the lady — I think it was a lady legislator — was set to introduce the bill, but we introduced ours at the session, and she just deferred to our bill because it looked better to her. It didn't give carte blanche ability to apply for a license just because you went to foreign medical schools. Many of the graduates of foreign medical schools were very well trained, but some schools were not up to our standards.

They had held a hearing for one physician whose hospital privileges had been revoked, and he came to appear before the Board in the

morning. He had an attorney with him. We recessed for lunch and came back, and he fired his attorney. He had a briefcase open with medical books in there, defending himself. Well, I looked, and he had a whole bunch of methamphetamine pills there.

You could almost watch him fall over the cliff. He was really mentally ill. We were able to find a district judge in Reno who had an emergency hearing to declare him mentally unfit to practice medicine. He never did get his license back, and he has since died. These are outstanding incidents, of course; they're not the run of the mill at all.

Occasionally the Board would meet in Las Vegas as a convenience for applicants. Easy to get to Las Vegas; more airlines coming in and so on. There was sort of a camaraderie feeling amongst the Board members themselves.

At that time there were no non-physician members on the Board. That occurred after I left the Board. I think the success of that has been somewhat mixed, at least early on with the non-physician members of the Board. But I think it's working out fairly well now.

What's the reasoning behind lay persons?

I haven't any idea. I think it's like the Open Meeting Law, and working on improving the quality of candidates, or the quality of the questions, or the quality of the examination.

The Federation of Licensing Boards had the FLEX examination, and that was a comprehensive exam. That proved to be a real help. When I went on the Board, each Board member would get assigned a couple of topics, and turn in questions. The applicants would write answers to questions, long hand. Some of their handwriting was just typically poor of doctors, some of the spelling and grammar was terrible. But the exams really weren't as comprehensive as they should have been.

I've had practically no contact with the Board since 1977. Not that I'm disinterested, but I am no longer privy to their meetings. I have no right to be, and that's fine.

What do you think about working with osteopaths?

Well, I think most physicians have come to accept osteopathic graduates much better than we used to. For a long time, thirty plus years ago, there was very little respect by M.D.'s for osteopaths. Part of it was kept alive by schools of osteopathy that would not let the accrediting boards answering to the American Medical Association in to inspect the training facilities, and faculty education capabilities, and so on at schools of osteopathy.

I think that has gradually changed to the point where osteopaths are generally more accepted now by the medical profession. At the clinic we have an osteopath. Our radiologist went to a school of osteopathy. At the hospital it was sort of unthinkable twenty years ago.

One of the concerns during your time on the Board was with osteopaths using the M.D.

Well, that's not legal. They had to use D.O., doctor of osteopathy, and they still do. When I officially retired, I wrote the State Board of Medical Examiners that I was retiring. I have some personal stationery with my name M.D. I can't use that stationery to use it up. I'm no longer licensed in Nevada. I just wrote to them a few weeks ago. Whether they will take action on it, I don't know.

For a long time the Board was very interested in people using the word doctor if they didn't have an M.D. The D.O.'s have to use Doctor XYZ D.O.; they couldn't use M.D.

Chiropractors are still in my book — this is a personal thing — an unscientific cult. Other people believe differently. But they are not acceptable by the M.D.'s, generally. My feeling goes back to when I was kid. This farmer in Wisconsin went down to the Palmer School of Chiropractors and paid them two hundred and fifty bucks, and in six weeks came back as doctor of chiropractic. You can't absorb a hell of a lot of information in six weeks, you know. Yet that feeling is not shared by many, many people. I can't say that they don't do any good, but my feeling is I don't trust them in their knowledge. But that's a personal thing with me.

The naturopath to me is a cult. We had a hearing once for a doctor we accused of practicing medicine without a license. He was a naturopath. We had people from the community who all came to the hearing. "He's a good doctor; he's a good doctor; he took care of me," you know. "Cured my gall stones." He gave them some medicine, and I guess one medicine caused little stone, rock-like formations in the bowel movements, so you could see you were passing your gall stones. That wasn't so, but that's the way they can do things.

Remember people are gullible. People want to believe that they are going to get well. They want to believe in figures whom they think they should respect, so that there's room for charlatans in every line of work. People are ripped off by plumbers, car mechanics, so-called doctors, and doctors, you know. There is no question but what there are bad apples in every line of work. Fortunately, there are fewer of them in some professions than in others, some lines of work. But often the chickens come home to roost eventually.

During your tenure on the Board, there was talk about a master board of the healing arts,

one examining board that would take care of all the medical fields.

I don't think that ever got off the ground. I'm not for it. I would not like to be on a board that had to license M.D.'s, dentists, chiropractors, osteopaths, naturopaths. We had a hassle with the acupuncturists. We fought the separate board of acupuncture tooth and toenail, but the fellow who was promoting it from Vegas, he spent one hundred thousand bucks to campaign. He gave acupuncture treatments to some of the legislators and the committee. They thought it was great.

We wanted not to have a separate board for acupuncture because we were working on it. There were four places that were doing some studies on acupuncture, but the legislature didn't listen to us. They formed it, and the guy who was setting up was going to have franchises, like McDonald's, all over the state. We had one here in Elko. It didn't last too long. We learned that one of the big proponents had been a tailor in Hong Kong a couple of years before, but he was an acupuncture specialist.

What was your objection to acupuncture?

Dr. O'Brien, Bill O'Brien, was an anesthesiologist, first one in the state. He told about a lady who had been in concentration camp in Germany who had to have surgery. She refused to be put to sleep. She wasn't going to get any gas. They did an operation on the abdomen with no anesthesia whatsoever.

Did they do a local?

No. She said she could take it. She did. I had my appendix removed under a local anesthesia because I'd eaten. Dr. Collett didn't

want to do OB the rest of his life, and he was afraid I'd go to sleep getting drip ether, so he did my appendix under a local anesthetic. I don't recommend it worth a nickel. We got it done, though.

One of the issues while you were on the Board was that of Continuing Medical Education, whether it should be mandatory or voluntary.

Well, when we started the clinic in 1948 we had, I don't know whether it was a written rule or not, but everybody was expected to go to medical meetings at least two weeks each year. The way was paid; the tuition was paid. But, of course, in those days the courses were fifteen dollars; now they are five hundred, you know.

I was a little bit upset with the concept of making it mandatory because we had done it voluntarily. I'm generally against mandatory rules and regulations, but I think that basically it's a good one. The problem now is going to courses that are approved by the accrediting organization. In getting a minimum of forty hours every two years.

The last time I renewed my license, two years ago I think it was, maybe three, I got a bunch of video tapes and had to answer exams on them. My back hurt so much, and because of the problems with the breathing, I didn't get a chance to go to good meetings enough hours. I was unable to do it. I think that's a valid substitute for actually going to the meetings.

How do you view some of the changes in the practice of medicine?

One of the things currently on the rise is managed health care which has some pitfalls in it. If the physician belongs to an organization in that category, he has a difficult

time referring patients to specialists who are not with that group because it costs money. And where money is the bottom line, it skews the physician's attitude toward patient care. I basically don't think that the American people are ready for rationing of medical care yet. It may come to that, I don't know. But I don't trust the federal government any more than I do a mule kicking me in the face. And that puts my feelings about the "health care reform" in a different category than the politicians.

What about a physician's independence?

Well, he has never been completely independent. He makes his own decisions, but he has to consider his patients in the community, the welfare and all. That's always true, but he becomes less independent in some of these health maintenance organizations or managed care situations. If he's hired by someone who is paying his salary, that person may or may not be a doctor, or may or may not be concerned about patient care as much as the bottom line, the dollar. So that the pressures can be different. Goals can be different, not necessarily better.

I think that's the thing that has concerned me most about government medicine, the bureaucracy toll. A number of years ago I got a snotty letter from a clerk in some insurance company questioning my reason for doing a Pap smear on a patient. I was infuriated. I called the medical director and said, "God," I said, "Part of practicing medicine is doing Pap smears. You are trying to identify cancer early."

He was very apologetic. He said, "Well the policy is saying that preventive medicine is not covered."

I said, "Well, all right. If that's the way you feel about it, fine. You will have to let that

patient know that." I'm not going to quit doing Pap smears when I see patients.

It's just like breast exams and mammograms. Statistically there are not too many that are found early, but if you find one out of a thousand, aren't you doing that person a favor? My wife died of breast cancer. A mammogram wouldn't have done her any good. On a Monday morning she showed me a little cyst on her left breast, oh, about the size of the head of a kitchen match. It was malignant. We thought a mastectomy cured it, but she died in 1987.

The earlier diagnosis can be made, the better chance you have of preventing that cancer from causing death for that person. Again, you're not saving life, but you may be prolonging some. You can't use statistics alone as criteria for deciding yes or no to do a particular procedure or to do a particular test. Nothing is 100 percent except death and taxes, in the United States. [laughter]

If, as in the case of Pap smears, an insurance company says, "This is preventive medicine; we're not going to pay for it," to a certain extent aren't they usurping your decision as a physician?

No. My decision in that case was to tell the patient, "Now, the insurance is not going to cover this, but I think you should have it done." If the patient refuses, I should document it in the chart: Mrs. Jones refuses to have a Pap smear done because the insurance company won't pay for it. But it's up to me to tell her that I want to do a Pap, but your insurance is not going to cover it, but you, Mrs. Jones, are going to have to pay for it. I don't know who pays or who doesn't, but I have to tell her that. You can't force people to accept medication or treatment.

I think the thing that concerns me most about government medicine is the concern about money dictating what type of medicine should be practiced. I think that's the wrong approach — I wouldn't feel comfortable if I had to live by that criteria in the practice of medicine. Here's a patient eighty years old with a broken hip. Years ago you just put a cast on, and they all died of pneumonia. Now many of them can be operated on and have a productive, comfortable, pain-free life for some years. Not everybody, no. But you don't want people to be foolhardy and say, "No, I won't do this," based on inadequate or incomplete or wrong information.

Sometimes it's not easy to make that decision. You are playing God to a certain extent; I realize that. I think in that regard patients should participate in decisions on their medical care. It should be open and above board, honest, based on the best information available, best knowledge available. But if they came in and told me I have to have an amputation of my leg, I would have to know what will happen if I don't have it. What are the potentials if I don't have it done, the risks? If I do have it done, can I grow another foot? These are all valid questions, valid concerns on the part of the patient.

There are times, particularly with patients in accidents who are unconscious, when we have to make medical decisions without the patient's consent, based on your understanding of the emergency and the availability of responsible relatives. You may guess wrong, but you have to live with your mistakes, too.

If the mistake is honestly arrived at, it can be just a mistake. In that respect, I think that with many of the bad medical results, surgical results, cases where the attorneys are trying to blame the physician are not just valid. In that respect I think the medical legal screening

panel has served a purpose for some potential suits. I hope they continue the medical legal screening panel. It is not expensive; it does not prevent suits from continuing if medical legal screening panel says it's a frivolous thing that shouldn't be brought in a trial. At any rate, it's a valid thing.

We do know that in many medical malpractice suits a judgment is rendered against a physician, but the attorney gets a third to a half of that judgment, you know. That love for money or desire for money on the part of many plaintiff's attorneys is responsible for some frivolous suits. I know that; I feel that way. It's difficult to get attorneys to agree with you. But also insurance companies have been guilty in the past of being niggardly in refusing to pay what seems to be just claims. So it could work either side of the coin. Not many of us are perfect. Speaking about everybody else but me! [laughter]

Philosophically, I felt much more comfortable in the days before insurance control of medical practice, both for patient services and for malpractice problems. I used to love to do obstetrics. I quit in 1986 because they were going to increase my premiums, malpractice premiums, if I continued doing obstetrics; increase it by fourteen thousand bucks a year. That's a whale of a lot of money. I had cut down to about a hundred women a year, and that would be one hundred and forty bucks per person. I couldn't pay for it, the clinic couldn't pay for it, and I couldn't ask patients to pay for it. So I said, "To the heck with it!" I quit doing obstetrics. It was about time anyway.

Every physician has to have a conscience as to what he can or can't do, what he should or shouldn't do. You know how the Indians

used to describe a conscience? It's a three-cornered metal plate in your head. It has sharp edges. If you did something wrong, it turned around, and the edges would cut and hurt. If you keep it turning long enough, the edges get dulled, and it doesn't hurt anymore. [laughter] That's a pretty good explanation. Can you describe any better conscience? But I feel sorry, I think I do, for people who don't have a conscience; I really do. Conscience is not always the easy thing to live with, but it keeps you on the straight and narrow a little bit. It's worth something, you know?

Can you think of any situations where medically your conscience has kept you on the straight and narrow?

Yes. I never learned how to do abortions, because when I grew up they were immoral and illegal and unethical. There were a couple of times when I wished I knew how to do abortions, or wished I knew somebody to whom I could refer a patient. On the Board you're obligated, if you know somebody who's doing illegal abortions, to tell the Board to start an investigation. So it was easy for me to turn down, but a conscience would have kept me from doing it anyway.

Even after it became legal?

I never was comfortable with it. I never learned how; I didn't care about doing them. I don't think that I've got a big moral opinion against them, but I've never been interested in learning how to do them.

It's not always easy to have a conscience. You know, if somebody gives you a thousand-dollar bill for doing something that you are not comfortable doing, there's a temptation. This book [pointing to a Bible] doesn't say it's money that's the root of all evils; it's the love of

money that's the root of all evil. There's a little bit of difference right there. It's not always easy to say no if your kids are starving, and need clothes, and haven't got any money or a roof over their heads. Money takes a pretty good chunk out of your resistance.

Do you think the motivation for the practice of medicine has changed in recent years because of money and the high cost of practicing? The high profit that can be associated with it?

I'm not sure that factors have changed. Maybe for some the acquisition of money has assumed greater importance now than it did fifty years ago or more. But I never knew any doctors who were starving, even though some were paid in pigs and chickens and potatoes or whatever. I have known physicians who were paid like that. They took it as a matter of course: grateful that they could do something to earn pigs and potatoes or corn, you know.

I think generally medicine is still a respected profession. By physicians in it, and by the public generally. Whether that will change or not, I haven't the faintest idea.

Looking at some early papers with the American Medical Association, one of the key words that they used in giving advice for guidelines of physicians was to maintain the dignity of medicine.

I think that's a valid concern and a valid recommendation. You are not just fixing cracks in the sidewalk or leaching a plumbing pipe. You've got human beings who deserve a dignified approach to their problems. To each patient his or her problems are important. You must regard them as important. They may be fancied problems, but they're still problems.

Each physician who is dealing with patients is going to run into situations where

he feels like he is playing God. You know, cutting off life support, you are playing God when that's the thing to do. Living wills. We've had patients sign them, and usually you respect it. But some people — say Italians or the Basque people — if there are four children and three of them say, "We respect mom's wish to cut off life support." One says, "No." You better not do it, because some attorney is going to get a hold of that person and sue the dickens out of you. And not that it's necessarily right or wrong, but that's the end result for some times. Have we got the right to say, "This person has lived long enough?"

I don't think physicians say I saved a life, but more accurately, I helped prolong a life. We're all going to die. We haven't prevented anybody from dying that I know of. So it's not proper to say, "I saved a life." I may have helped prolong a life. You see some of the congenital deformities that occur in newborns, that are not compatible with life. Nobody is at fault that you know of; it's not any medication, any drugs or any life style that caused it. It just was the accident of flipping a coin, and it stands on edge, you know.

The first delivery I ever saw, I was a junior intern at this hospital. One Sunday afternoon a general practitioner by the name of Joe King brought in a lady forty years old with a first pregnancy at term. She had eclampsia, hypertension, albuminuria, and edema. He called in the top flight specialist in St. Paul.

In those days interns were like worms; everybody stepped on them, but he was kind enough to sit down on the edge of the bed and discuss the case. Then they went to the corner drug store and said, "Moren, you better stick around." The corner drug store was fifty yards away, but we didn't have beepers; we didn't have anything.

They were halfway between the hospital and the drug store, and this lady convulsed

and delivered the baby in the convulsion. It had no skull; it was anacephalic. Well, that's the first delivery I'd ever seen. I didn't know what to do. I just put a wet cloth over its face; the baby couldn't get any air. Nowadays you have to let that child live; they'll usually live sometimes up to five days, even though you know they can't survive. It's a horrible thing, tough on everybody, parents, the nurses, doctors, everybody to see such a deformity even breathing, you know. That should have been enough to tell me to quit practicing obstetrics or doing obstetrics.

Did you have anything similar to that later?

Oh, yes. I've seen I think two or three other anacephalics. They're not fun! And the law nowadays is that you at least have to permit them to breathe, permit them to live. But I know of nothing that you can do to prolong their lives; they're just an inadequate shell.

You were talking about responsibility and conscience, and not setting yourself up as a god. What about when you have to make a decision like that?

You are not playing God to make that decision, to put a wet cloth over that infant's face so it can't breathe — [hesitation] I guess I am playing God. But knowing that little piece of humanity cannot live certainly more than a few days, you know, have a beating heart and breathing . . . I am not doing anybody any good by permitting it to live an extra day. Am I playing God to say, "I will not let it live this day"? I don't know; maybe yes. I didn't think of it that way at that time. It scared the liver out of me. As far as I know, nobody still knows why that happens during a pregnancy.

Do you think you were aware when you entered the practice of medicine of issues like this?

Only dimly. I had a strong loyalty to the concept of medical practice by the time I finished medical school. The faculty physicians that we had, some of them were wonderful teachers; others were lousy teachers but good people. But I don't think any of the faculty when I was there did anything but enhance the feeling of medicine being a good, noble profession. It demanded all that we could give. The smartest man in our class, the first one to go all through medical school at the University of Minnesota, a straight A in everything, died just a year ago. He became head of the medicine department at an eastern university. He had a fantastic memory. He was just a wonderful human being. I valued his friendship as much as any I have. He ended up teaching as well as taking care of patients.

Medical schools have basically teaching, research and patient care; it's a tripod. If you participate in all three legs of the tripod, this is going to be a good medical school, I guess. But not every member of the faculty can participate in all three things. Not everybody can do good research. After World War II a lot of research grants were given to people who really didn't deserve it, because they didn't have a research mind. Not all good physicians are good teachers. Not all good teachers are especially skilled physicians. So that very few are equally solid on all three legs of the tripod.

Looking at the faculties of some of the schools I've been in, some of them are just absolutely wonderful. Others I wondered how the hell they ever got a job on that faculty. But that's my opinion. I don't know many of them well enough to comment.

I enjoyed practicing medicine; I hated to . . . it was a bitter-sweet pill to retire, but I think

the main reason I wanted to retire was that I was afraid that I was going to make a mistake. I haven't been able to keep up reading enough recently. I have this emphysema, painful arthritis of the back, and my left eye went blind a year ago, and so I do have medical problems. Probably absorbing new knowledge could be more difficult. I think I've been able to pay attention to patient's complaints.

As far as I know I haven't made any mistakes of omission or commission, but I am so afraid. I'm getting afraid that I'm getting so damned old, that maybe I might make mistakes without recognizing them. I don't want to hurt anybody. It's one of the dictums of medicine, do no harm basically.

BEVERLY NEYLAND, M.D.

Dr. Beverly Neyland is a native of Gloster, Mississippi, and a graduate of Florida A & M University High School in Tallahassee, Florida. She completed her undergraduate work at Bennett College in Greensboro, North Carolina, with a dual major in biology and chemistry. She received her medical degree from Meharry Medical College in Nashville, Tennessee, in 1971. Choosing pediatrics as her specialty, she interned at Long Beach Children's Memorial Hospital in Long Beach, California, in 1971 and 1972. From 1972 to 1974, Dr. Neyland was in a UCLA-Harbor Pediatric residency at Harbor General Hospital in Torrance, California.

Moving to Las Vegas in 1974, she has practiced pediatrics in both group and solo practice. She has been involved in a number of professional and community activities. Dr. Neyland was the chief of pediatrics at University Medical Center from 1975 to 1985 and held that position at Sunrise Hospital and Sunrise Children's Hospital. She is a member of the National Medical Association and the Charles I. West Medical Society and

has been active in the Nevada Physician's Aid Committee. Her community interests include the Nevada Easter Seal Society, the University of Nevada Minority Aptitude Program, and the board of Rape Crisis.

Beverly Neyland, M.D.: I was born in Gloster, Mississippi, the home town of my father. My mother was on her way to California where my father was, at the time, in the navy. She was visiting in Mississippi with my father's parents for several months, so I was born there. My father, Leedell W. Neyland, is a professor of history and a university administrator, who is now retired from Florida A & M. My mother is a kindergarten specialist at the university laboratory school at Florida A & M High School.

I was raised in Florida, although my father received his Ph.D. from New York University. We spent a lot of time in New York; my pre-school and kindergarten years were in New York, and my brother was born there. Then for a while, my father taught at a small

college in Louisiana, Grambling University in Grambling, Louisiana. We were back in New York for a couple of years. Then my father taught at a small college on the coast of North Carolina at Elizabeth City, North Carolina. We moved to Florida, where I was in high school, and my parents have lived there ever since.

I have one brother, an attorney, who lives in Pittsburgh. He's an arbitrator for U.S. Steel, and so he's active in various types of organizations there in Pittsburgh. His wife is a banker, and they have one little girl.

My sister Katrina is a counselor for the pharmacy department at Florida A & M University. She is remarkable in that she has a handicap, cerebral palsy, that affects her locomotion so that she has always had multiple surgeries on muscles and nerves throughout her life; it has not slowed her down a bit. She is in a wheelchair, and she is probably the most independent, most positive person that anybody has ever met, just absolutely amazing. She makes up her mind what she wants to do, and she does it. She has a master's in counseling, and she has her own home, and she has her own car, and she does what she wants.

Anita Watson: You have a very accomplished family. Were expectations for you very high when you were a child?

Well, I think I grew up during an era when the question was not whether you were going to college, but what college you would go to. That was expected. My parents were educators, and they just expected their children to do the best that they could. My parents didn't put a lot of pressure on any of us, but we were all achievers, and we all made up our minds quite early what we wanted to do.

I think one of the good things with my parents was that they gave us an opportunity to see lots of different aspects of different things. You know, not just university life, but all kinds of various aspects of life, and they allowed us to make decisions on our own. I think that part has been really helpful because all three of us have real distinct personalities, each one in their own right. We all made decisions based on what we wanted to do, and our parents were encouraging for any of those things that we wanted to do, which was great.

My parents are still quite active in what they're doing. We tease my father all the time, because he retired, but he's doing some consulting work for the university. He's just as busy as he always was, and he is still able to get his golf game in; it's what keeps him active, and it keeps him really involved in what's going on. Plus, he's writing; he's written a novel that should be published sometime in September.

What type of history does he do?

He does European history, and he did black history, too, but mostly European history. My father always talked a lot about history periods; my brother and I were always fascinated by history. I think it's one of the reasons that I like to travel, because we talked about a lot of places and the things that happened.

Did you travel extensively as a child other than moving with your father's work?

Well, on vacations we would visit various colleges and universities along the way. During that time, in the early 1960s, we were not allowed to go to some of the universities, but we always visited them. We were able to visit most of the states, up and down the east

coast and a lot of the mid-western states. We got a chance to see a lot and learn about capitals of various cities. As we would ride along and visit these places, we would make it into a game. We also used to do capitals of countries. I remember that my favorite city was Kathmandu, Nepal. When I finally got a chance to visit it, I sent my brother a card, and I said, "Keith, I'm in Kathmandu." [laughter] Because we'd always talked about going there and wanting to be up in the mountains in Mount Everest and everything.

Did it live up to your expectations?

Yes, it did, it did. I was really looking forward to it, and I was not disappointed. But I think that the excitement about visiting some of the places started when I was a child, and that curiosity for seeing these places started then, too.

You said that you and your siblings knew early on what you wanted to do and were encouraged by your parents. Did you know from the very beginning that you wanted to be a doctor, or did you go through stages deciding?

Well, I think I started very young thinking that I wanted to be a pediatrician. I also wanted to be a dancer and to have a dance school. I was always interested in political science. There were a number of things that I looked at. But I think medicine was always something that I wanted to do. I'm not sure that my parents really encouraged me to go into medicine. At the time there were still not a lot of women physicians around, and so I'm not sure if they didn't discourage that. They wanted me to keep my options open, to look at everything and not to be so narrow-minded that I would miss out on some other opportunities. At one time I thought that

genetics was interesting, why things came out the way they did when they were combined into an area in certain ways. I think that my parents thought of that as more viable than medical school, but I wanted to be a pediatrician. That may have been good or may have been bad; I'm not sure that the decision for what you want to be should be done quite so early. It may be better to be a little bit more open-minded about it and give all fields of whatever endeavor you're going into a better chance, you know.

By junior high or high school, you had gone beyond the other things and knew that you were going to be a pediatrician?

I still took a lot of dance courses. By the time I went to college, I had a double major in biology and chemistry because they didn't have a pre-med major, per se, but I also had a minor in political science. An interest in everything was still there.

I went to Bennett, a small school, a liberal arts school, so I could get a lot of things in. It was an all-girls college. It turned out to be a great opportunity. I was able to be active in student government and to participate in a lot of various types of clubs and organizations associated with the university — I had a good experience out of that.

Bennett is a Afro-American college. It's been around for a long time, and A & T is another university in Greensboro that was predominantly male. So it worked out great for us at Bennett. [laughter] A great exchange program.

You were going to school and living in very turbulent times, both racially and with gender issues. What types of experiences did you have?

Well, I think first of all, my life may have been a little bit more sheltered because I've

always lived on a college or university campus. I think that gives you kind of a biased look at life, period, because you're in a protected environment. When I got to Bennett, it was still pretty protected; gender wasn't a real issue for me at that time because all the girls at the school were taking sciences. We had been taught such a pride at Bennett about our ability that we didn't see that as a particular challenge at that time. It was a turbulent time as far as being black or African-American during that time. We were real activists then. The student bodies used to march, and they were harassed, and there were threats, and so it was a real problem.

Were you active in this?

Very active in it. It was scary at times, but at the time, when you are very idealistic, your fear may be there, but you feel that it was a necessity for you to be there. So we did a lot of marching in Greensboro and going into places and sitting at counters. We were quite active during that time. There were mass arrests, and they would haul us all down to places, and then we were then released back to the schools. It made you really aware of how separate things were at that time, and how hard it was for college students. We were all trying to do something, but when you would go sit at the counter, you realized that there was such hatred out there for you. It was very eye-opening at that point.

We knew that things were happening when my brother was one of the first black students admitted to Florida State University High School during that time, during the 1960s. My parents would drive him over there and be very protective of him. I remember some of the threats and some of the name calling that he got when he participated in sports and stuff. And the phone calls — when

my mother would answer the phone they would harass her and make threats of burning a cross on our lawn. So my family were all familiar with that type of activity.

But when you are out there actually marching in a silent protest and have somebody come up and threaten you personally, you know, then that's a little bit more disconcerting, I think. We were all aware of that part of the struggle, and we knew that there had been some real physical injuries done to students in Greensboro, but we also realized that we were going to be a part of history and that it would change. We just weren't sure when, but it would change. And it did.

Were your parents supportive of your activities?

Yes, my parents have always been activists. They felt that no matter what community you were a part of, that you had to be active in that community; that you had to be willing to state what you believed in and be willing to stand up and back your principles. My father is an avid letter writer; he constantly sends letters to the editorial page. My mom even now is very active with the election board in Florida. She started out as a sitter during elections.

After Bennett you went on to Meharry Medical College in Nashville. What about medical school? Did you enjoy it?

Well, I think anytime when you're going to medical school, there's always the fear whether you are prepared. Going to Meharry, which is also a small, private, predominantly Afro-American institution — I guess my concerns were that I was coming from a small all-girls college and whether my preparation would be enough for the situation. Then you get there, you meet everyone, and you

realize that all the studying that you've done in college still doesn't prepare you for the load of information and data that you are going to come in contact with for medical school. I guess my one worry was that I was competing with people who were coming from really top-line universities, and how I would measure up? It's always interesting after the first battery of exams to find out that you can hold your own and that you're ready. You may have to study harder than anybody else there, but you can do it.

Meharry was co-educational. Were there many women in your class?

There were thirteen in our class, in a class of about seventy. It was the largest class of females that had been taken. We had one of the closest classes as far as the way we related with each other. It's amazing how we all know where everyone is. We keep in pretty good contact, which is great. It was a good experience.

Did all thirteen make it through?

Let's see — yes. Actually, no. One girl dropped out, I think. But she may have even come back the following year. Twelve of us females made it through, and the majority of the guys made it.

Did you deal with gender issues, or was it positive for women going through?

Well, when I went in for my interview, I'll never forget one professor who said, "Why aren't you wanting to stay home and have babies?" You know, that was in the 1960s, because there was no way that he could even primp his mouth to make a statement like that even if he thought it now. But at the time it

was interesting that somebody would think that. They weren't used to us yet, and I think there were a lot of jokes and things that were said that were truly chauvinistic. Now they couldn't do that, but you hang in there, you know.

The first two years of medical school seem to have been really disillusioning, not just for the females but for the males, too. I mean they seem to take you down to a very basic level. Sometimes it seemed harder for some of the guys who had been out and had been independent. To come to medical school was very degrading; well, not so much degrading, but it just took them down to a level that was very basic. It wasn't until they got into the clinical years, and they came back into their self-confidence and felt more self-assured that you could see the difference. But I think that's just medical school.

I thought that I had to work harder. First of all, I felt that as a female, coming from an all-female school, I was just going to have to work really hard. I wasn't sure if what I had had was going to get me through, but it did. But you had that doubt. I was always very, very afraid of anatomy — not so much anatomy, because I had done plenty of that when I was in college; I had taken every course that I could take. So I felt that I was ready, but the fact that we were dissecting out human bodies, I felt that I needed to take some extra time. I got permission to spend extra time in the lab working on my cadaver, and that only helped.

So it was internal pressure?

Yes. I just felt that I needed to give myself that extra effort for anatomy. It was kind of interesting that I didn't feel that I needed to do it with some other things. But with anatomy I really felt like I needed to spend some extra

time on the cadaver. It worked out well. I mean, the guys would always try to play jokes, and they knew that I was afraid of the body initially. I didn't mind working on the body, but I didn't want to see the face. So they would always tease me about that. But . . .

Did you ever name your cadaver?

Oh, yes, we all did; everybody names their cadaver. We had a female, and we named her Samantha, and we called her Sam. With Samantha everything that could go wrong, did go wrong with Samantha's body. Nothing ever came off where it was supposed to come off. [laughter] She was interesting. We knew her body, though, because whenever they would try to trick you, they would always use our cadaver. It worked out great.

You finished medical school and then went to an internship in Long Beach, California?

There was a program where you were matched with a program or hospital, and I matched with Long Beach Children's Hospital in Long Beach, California. That was really interesting because I remember the first time I arrived at Long Beach Children's Hospital my father had driven out with me from Florida. We walked in, and the program director walked up, called me by name, and said, "How are you?" My father was really impressed with the fact that he knew his interns that well. After my father left, I saw the picture of twenty-four interns that were starting, and there was one female and one black. I called my father, and I said, "It would have been very difficult for him not to know my name, as I was sticking out like a sore thumb." He definitely had to know who I was, you know.

That was an interesting experience. I think that they had not had a black intern there,

and they went out of their way to make sure that my experience was great. I probably had more opportunities to see and participate and do more things there because they wanted to make sure that my experience was good; and that turned out to be very positive.

When I was in medical school, at the time there were two predominantly Afro-American medical schools: Meharry in Nashville and Howard in Washington, D.C. As students, we used to go back and forth between the two universities for the student medical association that I had started at that time, so we knew most of the students. I figured that when I got my internship, I wanted to come to the west coast where I would see more African-American physicians. I was surprised to find out that there were not a whole lot more. In my particular program I was the only one. When I went into my residency program at Harbor General Hospital in pediatrics, I was the only Afro-American resident that they had during that year that I started. I was a little amazed at the numbers; I thought that they would be greater, but they weren't.

Did you encounter prejudice and gender bias?

Well, you get to the point where you build such an outer coating for yourself that you just learn to ignore a lot of things. There were things that happened that you knew are prejudice, but you couldn't deal with that because either you didn't have time or the energy when you are an intern, because you're working so hard. There were always the little things that let you know. Going into doctor lounges, and the TV would always be on a sporting event. There was nothing there as a female that you could watch. But you watched that, and you became very good at sports things.

There were things like on-call rooms; it got to the point where you just wanted a room. You didn't care who was in there, just so that you would have some place to put your stuff down when you were on call. The male doctors always had the doctor's lounge, and I could use that, but there were no separate dressing rooms set aside for females at the time. Either we dressed with the nurses or in a closet someplace. If you said, "Well, why don't I have a separate room?" most of the time you were ignored. They didn't deal with you because there weren't enough of you at the time to put any pressure on them to make those things change.

Gradually over the years we are beginning to see some of that change, but in some of the hospitals, female surgeons are still having difficulty with places to dress. They are still fighting about dressing lounges for female physicians. You know, they say, "Go in there with the nurses." Well, that's fine, but the male physicians have lunch brought into them and special amenities there. The nurses don't get that, and female physicians don't get that. That's an ongoing problem that some hospitals are correcting, and some are a little bit slower than others in correcting.

Are you as much of an activist now, do you think, as you once were?"

I don't think so. I'm still involved. I have always been active in the Easter Seal Treatment Center because of my sister, and I've been active in some things like the Minority Aptitude Program. I've been chief of pediatrics in both of the two main hospitals here and been out fighting for funds and changes and things in pediatrics. So I guess I am still active, but sometimes I don't think I have quite the enthusiasm that I used to have before, you know.

It takes a lot of energy.

It does take a lot of energy, and change of any kind can be very frustrating, or trying to get people to perpetuate change. I think people are changing, too. I think that some of the young minorities don't remember the activist periods of the 1960s, and they don't feel any urgency to want to do anything. They are kind of laid back and don't seem to have the fire that I think sometimes we had when we thought that we couldn't achieve something. Now there doesn't seem to be a whole lot of fire behind some students to get out there and push as hard. They are just a little more relaxed about it.

Do you think racism is more subtle?

Oh, yes, I think that it has definitely been more subtle, although I think in the last several years it's getting a little bit more blatant. I don't know if the kids now realize some of the slights that they may be getting, that they're just not recognizing racism. At the time when I was coming through, there were a lot of programs that people were purposely opening up for minorities to get into, and those programs are not there now. As I said, the kids just don't have the fire to go out after things like we used to have.

Back then, if you were going to try to get into medical school, and you got accepted to two or three medical schools, then you still had to make decisions. If you got accepted to a predominantly white medical school, you have to look at that. Do you want to go there and be the only one there at that time, you know? Then you had to say, "Well, what kind of social life am I going to have? Am I going to have any type of life other than medical school? Medical school is going to be hard enough. I had a support system in that I had

a family. But what other kind of social life am I going to have if I put myself in this situation? So that's something you have to look at.

Was that a factor in your decision to go to Meharry?

Yes, very definitely. After being in an all-girl school, to go to an all-white school would have been really isolating as far as I was concerned. That's something that you had to look at, you know.

Did you realize when you went to Long Beach that you were going to be the only woman?

No, no, that was a real shock; that was a real shock. I mean I was really surprised about that because my whole point in even considering coming to the West was that I felt there would be more minorities. I mean, it was California! Goodness gracious, they'd always been pretty liberal, and you just naturally assumed that there would be a host of us in medical school out here. But it didn't turn out to be that way, even at UCLA. It was really interesting and eye-opening at the time.

You were raised in the South, primarily educated there, and then you moved to the west coast. Your first practice was Las Vegas. Why?

Well, I was in L.A., and I had looked at various groups and practices, even in Long Beach and San Francisco. Whereas I loved San Francisco as a place to escape to, I didn't want to really be in practice there for some reason. That was like my escape city, and I didn't know if I wanted to work there. L.A., for some reason — I think it was just very laid out and had never really appealed to me. I wasn't sure what I wanted to do. I wasn't sure if I really wanted to stay in L.A., but I wasn't ready to come back to the east coast.

There was a job offered here in Las Vegas, and I came over to look at it. It sounded very exciting in that it was a group, and there would be several pediatricians and several family practitioners and internists. I thought that that would be a good way to start out and look at practicing medicine. Then I could decide what I wanted to do — if I wanted to go back and do a fellowship or something. So I came over and looked at it. It sounded like a good opportunity, and so I came and stayed.

It wasn't necessarily intended to be a permanent move?

No. But it turned out to be. In fact, I came with a group, and after several months I was disillusioned with the group. Another pediatrician here in town, Anthony Carter, said to me that if I wanted to I could share an office with him. I took him up on that, it worked out really well, and I ended up staying here.

What about finding acceptance in the community as a female, as an African-American, when you were finally in practice? Did you encounter problems in being taken seriously?

When I first started here, the group that I came with was a little bit ahead of its time. They wanted to advertise, and that was not the thing to do at the time, in 1974, although everybody does it now. That group was like the early stages for a health maintenance organization where there were going to be long hours; they going to be open extended hours. There were a lot of new physicians who had been brought into town. I think the concept was just not well accepted or well presented to the community at the time — or maybe it was too new an idea for that

particular time. Yet right now I look back on it, and the things that were being advocated at that time with that particular group are what's being done now. It was just ahead of its time.

Even though I made it onto the hospital staffs without any difficulty, after a certain period of time they would not accept anybody from this group because of advertisement or whatever the problems were. Whenever I would go to a meeting, not only would I be one of a few ladies on the staff to show up at the hospital meetings, but because I was with this group, it's like no one would associate with you. [laughter] You felt like you would walk in that meeting by yourself, and that was a little disconcerting, and that took a little getting used to.

The thing about medicine, once you start your practice and people think that you're doing good quality work, then that problem corrects itself. Tony Carter was one of the other guys that I was in the group with who later also left. We would go to the meetings, and we would sit with each other, so at least there was somebody to sit with, and that helped with other pediatricians.

Why pediatrics? You said from the very beginning that that's what you wanted.

I guess I've always thought that if you could start early enough teaching children to take care of their bodies, that they would do a better job when they became adult. If kids are healthy, they are going to be healthier adults, and I think I like the idea. It's very good preventive medicine if you can keep them healthy and can give them their immunizations; and if you can teach them good habits when they are young, you can prevent a lot of things when they're older.

In the 1970s we weren't talking too much about child abuse, or drug abuse with children, so

your ideas about prevention seems to have anticipated some of the problems that we're facing.

I think so, and not only in those areas, but we've also seen a change in the infectious part of pediatrics. When I first started out in medicine, we were having a lot of mortality and morbidity from meningitis, childhood meningitis, Hemophilus influenza meningitis. Now there's a vaccine, and we have not had a case of Hemophilus influenza meningitis in about two years in my practice. That's remarkable. In the past, sometimes we were averaging two and three cases a week just in my practice. That's a remarkable change. That disease had a high mortality rate, and it also had a high morbidity rate. There were a lot of eighth nerve damages with hearing losses, injuries to the brain, and some retardation, secondary to that. The morbidity may have been worse than the mortality in that it was long term.

Do you think your sister was a factor in you wanting to be involved with pediatrics?

She may have been. I guess even though Katrina had asthma and the problems with locomotion and a lot of surgeries, I never really felt of her as a being sickly or anything because she has always been so positive. She's remarkable; she really is remarkable. She has done the things that she's wanted to do. But I'm sure that a lot of that played a part in my decision to really want to stay in medicine and to make sure that children did well and got good care.

You mentioned that you've never been married. Was it a conscious choice to remain single?

No, I don't think there was any conscious effort not to get married. I think that I just

did not get married. Probably like all younger people or young ladies, I wanted to get married and looked a while at it and several times came very close to getting married, but didn't.

Were you busy with your career? Do you think it would have interfered?

I don't think so. I have too many friends who are married, and I think I could have balanced it quite easily. I don't think that career was a reason that I did not get married. It was just something that didn't happen, or possibly with the relationships that I was in, that I was not comfortable with marriage at the time.

You've had a successful, active professional life. You were chief of pediatrics at UMC. What exactly does being chief of pediatrics entail?

There's a period of monitorship that all new doctors go through, so you set up doctors as monitors for new staff members. Most pediatric departments are like the stepchild of hospitals; we don't get equipment because we don't bring in a lot of money. So I spent a lot of time when I was chief of pediatrics doing public relations, going out to various groups trying to get money donated to us for equipment. As chief of pediatrics you want to make sure that the running of pediatrics is as smooth as possible. With any problems that arise between patients and physicians or the nursing staff, you help mediate.

And you're a clinical professor. The University Medical School is split, isn't it?

Well, I think what they have done is that the basic sciences are still done in northern Nevada, in Reno, and a lot of clinical teaching

is done in the southern part of the state; particularly for certain areas. They have some professors down here, and they have some up there, and a lot of them go back and forth between the two sites.

You mentioned that you were involved with the Nevada Society of Women Physicians.

Well, recently we have organized a society for women physicians basically to deal with some of the problems that women physicians face, so that we could present ourselves to the community as a unified group. The organization has been really good for networking among women physicians; that has been excellent. We've also put on various conferences that were for women. We did a breast cancer conference that was really well attended. We had a plastic surgeon, a pathologist, a radiologist, and a hematologist, all female physicians, who talked to the public about breast cancers and mammograms. We've also done a program on childhood problems that was well attended with physicians giving talks on asthma, seizures, and immunizations. Various types of topics that were open to the public that were really well received. And we're looking at concerns about school lunches and safety in the schools and menopause; various subjects that we've just dealt with.

We've had a couple of political talks. We had Jan Laverty Jones, Barbara Vucanovich, and some of the female politicians come in and talk to us. We've looked at what may need to be done as far as lobbying for various things, so it's a proactive kind of group. It's been a real eye-opening experience, and we are trying to deal with some of the problems that we see as female physicians.

It's simple things, you know, like I said about the dressing rooms for some of the

female surgeons. Another little kind of funny problem occurred when they had physician's day. One of the hospitals had a female Marilyn Monroe impersonator who came out and had her picture taken with the male doctors. We said, "Well, what did you do for the female doctors?" You know, it's that type of irritant, just little things. [laughter] But the main thing is putting ourselves out, presenting ourselves to the community. There are some patients who would like to deal with a female physician. As far as female physicians, there are some who have reached a point in their career or personal lives and want to become part of a practice and to network with other physicians. And they can do that quite easily. That's been working out quite well.

You are also active in the Charles I. West Medical Society.

It's a part of the national medical society, the chapter that's here in Las Vegas. Yes, I've been active in that. Dr. John Crear was really instrumental in getting that started. When he got seven African-American physicians here, he pulled us all together and said, "We have to start this chapter here so that we can get some things done." He brought people from the national in so that we could get it organized.

It was through the Charles I. West Medical Society that we got the minority aptitude program going. I think the thing that surprised me when I got to Las Vegas was the fact that I learned through my practice and just in talking to kids in general, that there were so many kids who had no expectations after high school. Most of them saw themselves working on the Strip and not thinking beyond that. When you asked them if they'd even considered a career in health sciences, not even doctors of medicine, but

in health sciences or any profession, most of them hadn't thought about it.

Through the Charles I. West Medical Society we were able to, along with the medical school, set up a program to try to interest minority students in looking at health sciences. We had a co-director named Dr. Joel Lamphear from the university, and I was the co-director here. We were able to select kids from across the state. We averaged about twenty-four a summer, and we did it for about eight summers. The kids went up to the medical school, and we could show them the college, the University of Nevada at Reno, plus the university down here. They were taught about applications to college, how to go about getting financial aid. They were given tasks to do, assignments and reports, where they would have to go to the library for the research and work. Then they would have to present it to physicians and argue their case. Most of the minority physicians would go up and participate in that. The students were given good criticism, constructive criticism on their reports. There were also social activities for the students.

It was really eye-opening for the kids, and it was very eye-opening for the university, I think, to see that there were kids that they were losing. A lot of these kids would not even consider going to Reno or to the university. I think that the university was amazed at the quality of the students that they were dealing with, and I think they became more aware that maybe they were losing some of these students out of the state because some students were not even considering going to their institutions. So that made them aware that they needed to do a little bit more public relations and to look for some of these students. All in all it turned out to be a very good program.

What happened was that the co-director, Joel Lamphear, left and went some place

else, and after that it sort of didn't follow through. At that time they had gotten their first minority student at the medical school, and I think the pressure was off of them. They didn't feel that they needed to go on with this program. The program they have now is strictly up there. They have not brought the kids down here, which I think is a little bit one sided. UNLV should be participating in it, too, because mainly the kids see Reno and not so much UNLV. If UNLV is not going to participate in that program, they should have their own program for the kids down here.

We realized with the program that you're not going to get everyone going into medicine. I think we've had only maybe three that have actually gone into medical school. I would have liked to have seen them go into medicine, but I was more concerned with them staying in school, going to some kind of school. A lot of these kids went on to college, and they've done well. We had a couple of them going to law; a couple went into architecture. Some of them just went to college and are out with better jobs than they would have had. I think those are all positive aspects as far as I'm concerned.

Did you target gifted students, or did you try to get the full range?

No, we targeted high achievers, gifted kids. We felt that there were a lot of remedial programs out there. We wanted to reward those kids who were hard workers, and that's who we dealt with. It turned out to be quite good, and it was entertaining and very rewarding to those physicians, minority physicians who participated in it. It was really fun; it's a good program.

You're very active in Easter Seals, and you did mention that was partially because of your

sister. What all have you done with Easter Seals?

Well, I've been on the Easter Seal board for many years, and I have been active in their telethon for fund raising and various dinners and projects that they've done around the state. On the board we make sure that programs met with standards and that the money that was raised was used here within the state and so on. I've done that for years. I still help out with the telethon every year; it's exciting. It really is, and we are able to get some money through polling. Usually I've polled the physicians, and they hate to hear from me once a year, but I get them anyway.

What about your work with the rape crisis center?

I was asked to be on the board for that. I only did that one year, and that was really interesting. I think that's one of the areas that you really have to be ready for. I think that, as a female, you become very emotional about some of the things that you deal with in a rape crisis — dealing with the victim and the family and everything. That's an area where people need to be active and participating, but it takes a lot out of you emotionally.

I see a fair amount of child abuse, of sexual abuse, and that in itself is emotional. Also time-consuming with following through to make sure that patients are getting what they need and that the parents and the counseling is following through like it should be done, and dealing with the legal aspect of it.

You are required by law to report?

We are required by law to report; that's not the problem. I think the problem is that we don't see speedy justice a lot of times. Cases

are delayed, and we get subpoenaed and subpoenaed and subpoenaed, and we have to appear, but obviously the perpetrator may not have to appear. So it's a little frustrating for those of us who have done it over the years.

We have been quite successful at getting a SCAN Team set up. This is a sexual abuse team with a social worker and a physician and Metro and juvenile and a whole group of people who are involved right from the beginning to help out with sexual abuse cases. That has worked out very well; we seem to be getting better action done on the case because everybody is involved with it.

Are there times when it is a difficult call to make? It has tremendous consequences for the family. I would think that's a burden for you as a physician.

Well, the thing that you, as a physician, keep in mind is that your main concern is protection of that child. And the way most pediatricians deal with it is that we tell parents that we don't know who may have done this, but for the protection of the child this is what we're looking at and these are what our concerns are. I think that you have to be very forthright and very honest with the parents or the caretaker about your concerns and dealing with this. A lot of times parents are hurt and hostile because somebody has violated their child if they're not involved in it. You're dealing with a lot of different personalities and emotions at the time, and that in itself makes it a little bit more difficult.

I think that the SCAN Team helps. The way it's done, the story doesn't have to be told four hundred times to four hundred different people or agencies. By having everybody there at the call for this, they work as a team effort and this has really, really helped: the patient, the parents, the physician, the legal

system. It also helps in getting things set up for counseling and the needed therapies that are there for the child.

With the amount of child abuse I see in my practice or through the hospital, it was too draining for me to continue with the SCAN Team. I felt that some other people could be better, could better benefit with that than I could at that time. I think one of the things you have to know is what you deal with best, and I wasn't quite sure that that was really my forté, you know.

RICHARD PETTY, M.D.

Born in 1914, Dr. Richard Petty is a native of Hooppole, Illinois. His father was a general practitioner, and his mother was the postmaster there. The family moved to Mt. Carroll when his father joined another practice. Dr. Petty graduated from high school in 1931, and he received an A.B. degree in Chemistry, with a minor in Zoology from Findlay College. He took graduate-level courses at Northwestern University in parasitology and embryology.

Dr. Petty received his M.D. at the University of Illinois in 1940, and served a one-year internship at Southern Pacific General Hospital in San Francisco. On his way back to Chicago for a medical residency, he met with Dr. Fred Anderson, who was leaving for military service. Dr. Anderson convinced him to take over his medical practice in Carson City, and Dr. Petty moved there in June, 1941. His own medical career was interrupted by wartime naval service; then he resumed practice in late 1946.

Dr. Petty was instrumental in establishing the Carson-Tahoe Hospital in 1949, was elected to the hospital Board of Trustees and served as chief of staff. He has been active in state medical

politics as a member and president of the Nevada State Medical Association. He received the A.H. Robbins Award for outstanding medical practice and community service in 1977. He served on the Nevada State Board of Medical Examiners from 1941 to 1943 and again from 1961 to 1969.

Richard Petty, M.D.: I was born and raised in a little hamlet in northern Illinois by the name of Hooppole, Illinois. My father had recently finished his postgraduate work at the University of Illinois College of Medicine, and set up a practice in that little community, which was a farming community, largely.

I was born in the home, which was common at that time. An adjacent city doctor delivered me, and word has it that I was a little premature. Instead of an incubator, they set a bassinet on a steam radiator and kept me warm. At any rate, I managed to survive, and I resided in Hooppole, and had most of my elementary years in the grammar school there.

I had a sister that was born about a year after I, and then I had three other sisters that

died in infancy — one of them at two weeks, one at eighteen months, and one at two and a half years. All of them died during the World War I flu epidemic; I was about seven or eight at the time. At that time there were no antibiotics or anything of that nature, you know, and people often developed a complicating pneumonia or meningitis. At any rate, within a matter of three days they all died.

Anita Watson: That must have been devastating to your family.

Yes, it was quite an emotional trauma; that's right.

I would wonder if it would be particularly so for your father, being a physician and helpless?

Oh, yes. In those days there were no antibiotics, and we were, oh, I guess, about forty or fifty miles from a hospital. The hospitals in those days were not equipped to do much more than just give supportive care or maybe some surgical procedures. For infectious disease you were almost at the mercy of Mother Nature.

When I was twelve, my father joined another doctor in Mt. Carroll, Illinois, in the practice of medicine. My mother hadn't gone to college but had graduated from high school, and started work in the local post office and finally became a postmaster in Mt. Carroll. Mt. Carroll was a community of about eighteen hundred. Hooppole was probably a community of about four hundred, with surrounding farm area. I think I was in about the seventh grade at the time that we moved, and then I finished high school in Mt. Carroll. This was in the days of the Depression.

When I graduated from high school in 1931, my father had a patient and a friend who

was a minister, who helped him out financially by getting me a church scholarship. The first year I spent at a little denominational college in Mt. Morris, Illinois, which was about thirty miles from my home. I took the basic subjects that you would take in the freshman year, and the following year the school, I'm not sure just exactly what happened, but at any rate, they closed. All the transcripts were sent to Findlay College in Findlay, Ohio, which was another denominational school.

When you say denominational, what do you mean?

Church of God. There's not many of them out in this area; most of them are in the East — Pennsylvania and east of the Mississippi.

Because of my church scholarship, I had my residence in a ministerial dormitory, with embryonic theologians. I think there were fifteen of them; another student and I were the only ones that were not theology majors. To graduate from Findlay, I had to have eight hours of Bible study. So I took four hours of Old Testament history and four hours of the life of Christ. I've long since forgotten most of it, but at any rate I took that to graduate — eight hours of theology. I graduated in 1935 with an A.B. degree, major in zoology, with a minor in chemistry.

What was it like going to a church school and being one of the non-ministerial types?

Well, as I said, you had to have eight hours of Bible, and every morning, at 10:30 in the morning, they had chapel for a half an hour. I don't know whether the curriculum has been changed now or not, but it's still in existence. It's grown; it's called Findlay University now. Just as a sort of a side interest, Nancy Grundy, Dr. Grundy's wife is from Findlay, and she knows all about Findlay College.

Was it an all-male school?

Oh, no, it was co-educational.

Were women going into the clergy at that time?

Yes, there were women going into the clergy, and also into education. Some of them were taking scientific courses and pre-med.

Did your family emphasize education?

My dad — if I can just relate an incident as an example. I never did care for the English subject, and I went along and managed to get through English with C's, and finally when I got into English 4, my English teacher said that she had a crowded class and she had to weed a few of us out. She told me, "Well, I don't think you're capable of passing English 4." My dad — I can remember yet — went up and just raised all kinds of hell, if you want to put it that way.

He said, "He's taking English 4 even if he flunks." So I got by in English 4; I had to have that to get into college, you know. I took English in college and did very well.

Yes, my dad wanted me to go into the sciences. He really didn't encourage me to get into medicine, because a family doctor in a small, rural community has a tough life. It's twenty-four hours a day, and there were no hospitals or anything like that nearby. If you did go to the hospital, you had to go quite a distance. He delivered a lot of babies at home, and then later on he traveled about thirty miles to the hospitals to deliver babies. He was practicing with another doctor, and they were the only doctors within a radius of about, oh, thirty or forty miles.

He had a family practice. What type of medicine would you be practicing in a farming

community? Would there be injuries because of machinery?

Well, if there were any major injuries, naturally they'd be taken to the hospitals in the larger communities. We were near Clinton, Iowa, and Kewanee, Illinois, Rockford and Freeport — in that area. Usually they were transferred and referred to an appropriate surgeon or orthopedist or whatever in those areas. But I'd say a good 75 percent or maybe higher of medical problems in a community like that can be handled by a family doctor. His office was adjacent to the home, and, as I recall, there was never a night went by when he wasn't disturbed.

Did your father keep evening hours?

Yes, evening hours, and they'd even go to work Sundays. A lot of the farmers found it convenient to come in on Sunday when they went to church or something of that nature. They'd more or less show up, and he'd be there. That's essentially what it amounted to. A lot of house calls. He made house calls, the first that I remember in a horse and buggy, and then with an old Model T.

I think we have something of a romanticized view of the family practitioner rushing off in the horse and buggy and doing surgery on the kitchen by the light of a kerosene lantern. Would you say it was romantic, or . . . ? [laughter]

Well, I suppose you might say not scientific, really. [laughter] But that's the best they could do in those days. As time progressed, and when I got into medical school, they had better facilities. But as a child, I remember it was pretty crude.

You mentioned with your sisters that there were no antibiotics. Did they treat things

just symptomatically, just try to keep them comfortable?

That's about what you would have to do. If you were called to see a sick patient, you tried to reinforce Mother Nature — be sure there's plenty of fluids, and there weren't such a thing as IVs in those days. They gave gastric lavages, you know — a tube down and put fluid into the stomach. In other words, it was crude medicine; they didn't have all the modern things. And, like you say, what could you do? It was just general supportive treatment and moral support.

Did your father do much surgery, or was that left to the hospital?

He worked with a surgeon in nearby Freeport, which was about thirty miles from home. He would take surgical cases over, and he would assist. To my knowledge, he didn't do any primary surgery.

After you finished at Findlay College, had you decided at that point to go into medicine?

I decided to go into medicine a little late. I was going to go into the educational field, and so I thought I'd take some postgraduate study at Northwestern University. Well, at Northwestern University, I took more biological sciences and chemistry, and I took as my major subject parasitology. I was interested mainly in parasitology and embryology. When I got into that field, I got more interested in medicine.

That's something that I would associate with South America. What kind of parasitology were they doing in Chicago?

Well, in medicine in those days, nobody ever thought of parasitology. You know,

there are a lot of parasites that we have, and I became interested in those that affect the human. There's all sorts of others that affect the animal kingdom. So I decided after I had that course there that I would go into medicine. I didn't write my master's thesis, but I had all the necessary credentials.

After I got through with my postgraduate study in parasitology and embryology, I decided that I was interested in medicine. I wasn't interested in the type of practice that my dad had, but as things evolved, I did finally do that sort of thing.

My dad graduated from the University of Illinois College of Medicine in 1912, I think it was. He had a couple of acquaintances there, and he recommended me to them, and I got into medicine that way.

What did your father say then when you told him what you were going to do?

Oh, he gave me all the support I needed. As I told you, I had gone to this denominational school because of free tuition. I worked for board and room, kitchen work mainly. I learned quite a little about cooking and preparing foods, like peeling spuds and that sort of thing. When I got into medical school, I worked in the hospital cafeteria as a busboy and as dishwasher.

Was that a little tough? Holding down a job and going to school?

It was convenient, because it was right in the university hospital. I'd come in and have lunch and go and wash dishes, or I'd bus dishes. I would eat on the run more or less. I learned to eat fast that way — sort of gulp the food down. But it worked out all right.

You did medical school at the University of Illinois. How did you feel about medical school?

Well, I think in the freshman class we had something like 140 students; out of that number, after the first year, there were about 80 or 90. So the attrition rate for the class was pretty severe. You just keep your head to the grindstone and study and attend your classes, and don't play around any — just keep it all business — anybody can do it if motivated.

Well . . . [laughter]

There's a lot of people that go to college and have lots of potential, but they don't apply themselves. The same thing with medicine.

What about the shift from a small town? The University of Illinois — this is in Chicago? [laughter] Chicago's a big city!

I had a little indoctrination, you might say, into getting away from home, because Findlay College was about six hundred miles from my home in Illinois. I used to take the train and go through Union Station there in Chicago, and then transfer on the New York Central out to Findlay. Over the course of four years, you learn quite a little about big city life.

While I was in medical school, I had a sister on the west side of Chicago, who was married, and her husband was with the transit system there in Chicago. I would go out to see them periodically. And then, of course, when I was a sophomore in medical school, in 1937, I got married.

To Lucille?

Yes. In those days, if you didn't have a job with a satisfactory income and a house to carry your bride over the threshold, you shouldn't be getting married. Lucille was a nurse, and she worked at Passavant Hospital in Chicago. Actually we kept it a secret until

I graduated from medical school. She lived at the Passavant Hospital, and then in our junior year we got an apartment. The apartment was a short distance from her hospital work, and I commuted to the University of Illinois, which was, oh, just, oh, about a half an hour ride by bus.

But you didn't tell anybody that you were married?

My dad found it out actually when I was a senior. He made an unexpected visit to Chicago, and he didn't really care. But it was a social stigma, maybe; in those days you didn't get married unless you had a job, and your wife sure didn't work.

There might have been a negative reaction because she was working and supporting the family?

Right, right. In fact, when we came out here to Nevada, of course we were just starting out and didn't have a dime. I had to borrow money to buy a car to come out here; we were in hock. Most everybody now, if they have a spouse that can work, they work. No way then! You wouldn't do that! You were advised not to have her work. If I wanted to present any kind of an impression in the community, I shouldn't have my wife working. That's what it was in those days. But after World War II, everybody worked — men, women and so on.

Was there a danger of her losing her job if they found out?

Oh, no. That's one thing, a nurse could get a job anytime, anyplace. But she didn't say she was married when she was working there. [laughter] I'm sure it wouldn't have made a difference. I had a couple of classmates that

were married, not secretly, but they, too, were married. All of the others were single.

You did a rotating internship?

I mentioned that we were pretty destitute financially, and in those days interns didn't get anything for their work, except board and room. Residents got, I think, something like ten or fifteen dollars a month. Well, I looked through the various approved hospital training programs and found one out in San Francisco at Southern Pacific General Hospital paying \$25 a month. At that time Southern Pacific took care of their own employees; had their own hospital and their own medical staff.

That's where I had my rotating internship. It was a big building right at the edge of the Golden Gate Park panhandle. I don't know whether the building is still there, but, of course, Southern Pacific has long since abandoned that type of operation.

They went all the way down to Los Angeles, all the way out to Salt Lake. There was a big concern to get people in from Ogden, Utah, and from down in San Diego. Any injured rail man or anybody with a chronic ailment of any kind, were referred to the Southern Pacific Hospital. They brought them in on the train.

The staff was composed largely of UC and Stanford professors. They were on a contract with Southern Pacific. Obstetrics, pediatrics — we had this at St. Francis Hospital. St. Francis Hospital was one of the bigger hospitals in San Francisco at that time. The staff there was made up of medical people from the community of San Francisco, as well as the universities.

I was there till June of '41, when Lucille and I got on a train and headed for Chicago where I was going to take up a residency at

Cook County Hospital, a general residency. In those days they had a general residency, and then you decided on a specialty after that.

At Colfax I received a telegram from Dr. Anderson, who was practicing here in Carson City. He had found my name from the Southern Pacific Hospital when he went down there to try to find somebody who might take over his practice, because he was leaving with the Nevada National Guard in September.

That was Fred Anderson. He was practicing at that time in Carson City, and he was also secretary of the State Board of Medical Examiners. The telegram read, "Stop in Reno at the Golden Hotel," (which is no longer there) "and meet Dr. Fred Anderson. He has a proposition to make." Well, we did stop there, and we checked in there about ten o'clock. We were waiting there at the lobby, and finally we decided that we were tired, and we'd get a room and go to bed. At about two o'clock in the morning, which was typical of Fred Anderson, we got a call.

So we got dressed and went down to the lobby, and he introduced himself and said, "Sorry to be late," but he wanted to know if I would be interested in taking over his practice. We could practice a few months together, and he could show me the way around. He had to go with the Nevada National Guard, which was called to active duty in September. Well, we talked it over, and I realized at that time that the war was probably going to call me, also, at a future date, so I thought maybe that'll be a chance to pick up a little money. So we decided, after we came over here and he showed us around, that we would come to Nevada.

At that time, during the war, strategic metals were all the rage; precious metals were out. The mining camps were closing up in Virginia City and Silver City. A mining superintendent up there was leaving, and he had a home up here on Westview out in the

southwest edge of town; there weren't any other houses out there at all. He wanted to sell it as was; it had a little furniture in it. I didn't have any money, but Dr. Anderson put up a little money for me to hold it. So I bought a two-bedroom home with a nice, big lot and furnishings for forty-five hundred dollars. We sold it during the war, when I went in the service, because we weren't sure we were going to come back here.

At any rate, that's how we got started in Carson City. We went back home, and I had an uncle who had a Plymouth car agency. He sold me a brand-new Club Coupe with a little seat in back of it for \$600. We came out west, then, with all our belongings, which wasn't too much. [laughter]

This is quite a contrast from Illinois. [laughter]

Oh, yes. Illinois, the part of the country I came from was all agriculture and more or less flat country. A little hilly country where we lived in northwestern Illinois, but all that middle-western territory is flat country, you see. The mountains are entirely different.

Did you like the contrast?

Let's say, Lucille didn't particularly like it at first. But the longer she stayed in a high, dry climate, the more uncomfortable it would be to go back home with the heat and humidity. Here we have heat, but it's dry heat; the same thing with dry cold.

She liked to hike, and she did a lot of that. We had a little place up at Fallen Leaf Lake in back of Stanford Camp. We spent a few weekends up there. I didn't spend many of them, but she and the girls went up quite a lot for twenty-six years — at least twice a month with guests. I went up on weekends when not on call.

Going into practice, our first agreement with Dr. Anderson was that he would pay me a salary of \$250 a month. Office calls were a dollar, house calls two and a half. You can see the difference between then and now. I delivered a baby, prenatal care, and six weeks postpartum for \$75.

There was a Dr. Thompson in Minden, who was leaving his practice. Minden at that time didn't have anybody else there, so we had a part-time office above what used to be the bank building, opposite the Minden Inn. I had an office there for about, well, close to six months. Then Dr. Anderson left, and I had to come back and man the office here. Our first office was in the Industrial Commission building, which was where the Bank of America is right now. At the corner of Carson and Musser and Proctor — between the two.

How was the office set up?

The Industrial Commission was on the north side of the building. Dr. Cavel, a dentist, was upstairs. George Sanford, a prominent Nevada attorney, was up above. The other half of the building that the Industrial Commission didn't have, we had as an office. We had a reception room, an examining room, and treatment room, combined. We had a fifty-milliamp X-ray in back, which we used for extremities and that sort of thing. But that was before the war. We did our own lab work, blood counts, urinalysis, that sort of thing. We had a receptionist and a nurse.

Did you have to buy into the practice?

No. I didn't buy into it. He offered me the salary of \$250 a month, and then after he left, he got a percentage of what I took in. Actually, if I didn't make a living wage, something like \$500, I didn't pay him anything. I can't recall

now just how much I did give him, but at any rate, he didn't charge anything else. It was our intent that he was coming back to Carson City, and I was coming back to Carson City, and we were going to set up practice then together. However, when he got out of the service (he got out about a year ahead of me), he decided to go to Reno.

When Dr. Anderson went into the service, I took over as a solo practitioner in Carson City. There was one other doctor in town, Dr. James Thom, and Dr. Hand was in Gardnerville, and that was all the doctors we had in this area. My practice was built up gradually by word of mouth, chiefly. Dr. Anderson's nurse became my nurse, and, of course, being a small community, why, she knew everybody, and she more or less was my public relations department.

The practice consisted of the usual office calls for various and sundry ailments, upper respiratory infections and gastrointestinal disorders. I had quite a few obstetrical cases at that time after a period of about a year; we didn't have a hospital here, so we delivered most of them in — I suppose you'd call them delivery homes. One was operated by Mrs. Noonan and another by Mrs. Litton. Dr. Thom and Dr. Hand and myself used these delivery homes. I used Mrs. Litton's in particular, which was on the east end of the Proctor Street. There were even a few babies — I remember two or three — that I delivered out at Dayton in the home.

Of course, obstetrics is a good way to build a general practice because with young babies who grow up, you naturally treat their childhood diseases and their medical problems along with those of the rest of the family. We did do some hospital work at that time by commuting back and forth to Reno. I was on the staff at Saint Mary's as well as Washoe Medical Center,

and we took surgical cases over there. I worked with Dr. Anderson while he was here, but after he left for the service I used Dr. Ed Cantlon or Dr. Vernon Cantlon as my surgical consultants.

I'm trying to think now who other specialists were in the practice at that time. There was a Dr. Tuttle, who was a urologist, an internist whose name I can't think of off hand, and Dr. Palmer was a pediatrician. Being in general practice and having no hospital, you naturally called consultants because you occasionally ran into the need for hospitalization and special consultation. In my office we had usually a visitor from Reno giving the anesthesia when I did tonsillectomies in the office. I wouldn't do it that way now if I were going to do it, but that's what they did a lot of, so-called minor surgery.

I was a state orphan's home physician after I was here a while. We had a lot of the orphanage children and took care of them for their various needs.

How did that work? Did you go and visit on a specific day or did they just come in as they needed you?

They were brought in mainly, but occasionally you would make a house call for someone.

Is this the facility on Fifth and Stewart?

Yes, but the building is no longer there. They had a big stone building; it was constructed of stone that was furnished by the prison quarry. The same with a lot of the other buildings around Carson.

You came to Carson City in June, 1941. How long were you here the first time?

I got my orders to go to the navy in — I think it was April of '43.

Were you drafted?

Well, in Nevada we had a program for doctors called Procurement and Assignment. They took an older doctor from one community and put them in another where they were needed. In this particular instance, Virginia City was folding because the precious metals were declining, and they brought Dr. George Ross from Virginia City down to take over the practice. He was secretary of the State Board of Medical Examiners for a long time, too, during the war. He came into it about the same as I did.

What was Virginia City like when you first came? Did you go up there to see it?

Well, it had a population that was not quite as big as Carson, but about fifteen to eighteen hundred. They had mines, and most of the mines were shaft mines, not the open pit mines like you see now. Going through there one day, I recall the shifts were changing around eleven o'clock, and miners came out with their headlamps, and usually full of dust and mud — they were mucky, because I understand the mines in Virginia City went down to hot water. That's why they really had to discontinue some of their mining in shafts, because of the water that they ran into.

But there were mines from Virginia City down across the Divide to Gold Hill, and on down to Silver City. One of the bigger mines — more or less mining as we know it today — was done by Bill Donovan. The Donovan mill was at the base of Silver City there; you probably notice if you go up the back way to Gold Hill and Virginia City, Silver City. The big mill on the right was going pretty good when I first came here.

They were moving rock. The road that goes up there now is one that was built by Donovan Mining. They got permission to move the road over there, because there was gold under the old road.

[laughter] They were following the vein, which would have been perfectly legal with the apex law.

Sure, sure.

Were you aware of Virginia City's history at the time that you came?

Not completely. But before I actually moved, when I went back home to pick up my car to come back out here, one of the druggists there in Mt. Carroll had been out here. He asked me where I was going, and he said, "Oh, you'll like that territory out there." He named all the towns: Virginia City, Gold Hill, and Silver City, and told me quite a little about it. But it was entirely new to me, really. I didn't learn a whole lot about it until I came.

How did this Procurement and Assignment program work?

Well, I think it was legislated as a means of getting doctors into the service during the war. It wasn't exactly a draft, but it was a matter of taking care of a community that didn't need all the medical personnel that they had and putting someone someplace where they wanted to take a doctor out, you see. I don't know what his first name was, but Dr. West in Reno was head of it. You've heard of the Cantlons? The Cantlons and Dr. West were in partnership at their office. I think that some of the doctors volunteered to go to the service, while others didn't particularly volunteer, and were essentially drafted by Procurement and Assignment.

When I got my orders with the navy, I was asked to report to Farragut, Idaho, where they had a boot camp. I was to be indoctrinated — all the officers in the navy were to be indoctrinated for six weeks. Well, I was to be sworn in by some naval officer, and it just so happened that Lt. George Gottschalk was here on leave, so he swore me in.

I went down to San Francisco to pick up uniforms, and came back, and took off for Idaho. I was there only two weeks examining boots as they came in. When I went in to the service, they asked me what I wanted to be in, which branch. I said navy air. I wanted to get into either an aircraft carrier or an air station. Well, my first orders were to the USS Casablanca, which was the first escort carrier that Kaiser built. He converted these merchant ships into little escort carriers; there were fifty-five of them, and ours was the first one. It was about, oh, maybe six months before we really got on the ship, because it hadn't been in commission. Then for about five months we strolled up and down the Straits of Juan de Fuca, training pilots for carrier landings. The first nine months I was in the navy was a good duty. There wasn't much of any experience medically except just taking care of ship's company for colds and that sort of thing.

I think it was in March of '44 I got orders to the CINCPAC medical officer's pool, which was a pool of medical officers that were assigned to various ships that were going on Pacific island invasions. We were in the Gilberts, Marshalls, Marianas, then down to the Dutch East Indies, Hollandia, and then up to the Philippines. I was in on the two invasions on the Philippines. In the Lingayen Gulf I had a ship knocked out from under me, and I was transferred to the GCT5 USS Rockymount. Anyway it was Admiral Royal's staff ship, and we staged there to go to British Borneo.

The idea was that they were going to put a pincher movement on Japan. Go on Iwo Jima and Okinawa, and then they were going to go from Dutch East Indies, British Borneo up to Singapore and on up.

Well, in April 1945, I got orders to come back home. At that time I was in Tarakan Bay, Borneo, and there was no major shipping out of there. I hitchhiked a ride on one of the Mitchell bombers, a small bomber, and they flew me from British Borneo to Leyte Gulf in the Philippines. From there I got a ship, a troop transport, back to the states, and in about three weeks I was back home.

When I got back here, after about a month's leave after sea duty, I was to report to the U.S. Naval station in Pensacola, Florida, and the School of Aviation Medicine. I went down there and graduated from their School of Aviation Medicine. I didn't take the flight surgeon's course, because I just didn't want to do any flying. I was an aviation medical examiner, which means that you are stationed at naval air bases. From there I went to Corpus Christi, Texas for a brief period and then to Los Alamedas NAS in southern California, where I stayed until I was discharged in the fall of '46.

You've mentioned that you were in Borneo, British Borneo. Did your parasitology come into play there?

No, I wasn't there long enough. I was on the admiral's staff there, and most of my work was administrative duty. There wasn't a whole lot of medical experience from the standpoint of that duty.

I did have one experience that I'll never forget. We had a ship in the group that didn't have a doctor, just had a pharmacist's mate, and they had a man with appendicitis; at least that's what they said. We were in the Sulu Sea where there were quite a few Jap subs,

and they didn't want to stop and transfer, so they went alongside, and we went across to the other ship in a breeches buoy. You sit in a rope seat, like a swing, and there's a rope with a pulley on it going from one ship to the other ship. As I went down, I got my tail wet by waves coming up.

We finally got over there, and we did find an appendix, and we took the appendix out and got back on ship. But that's about the only excitement I had when I was with the Admiral Royal staff.

I imagine coming between those ships was exciting enough. [laughter] What about doing surgery on a ship? Isn't it difficult?

Yes, but you got used to that. They had lots of nice equipment, or good equipment. Surgical table, lights, the whole thing. There is a little bounciness, but if it's a rough sea, they usually try to get to a more quiet sea. As it was, it wasn't that rough; in those big ships they can go through pretty good breakers without having much motion. They were going about, oh, I imagine, fifteen to twenty knots.

When you were discharged from the navy, you came back to Carson City.

I came back to Carson City. Now, the story with Procurement and Assignment was that when the doctor returned, the doctor who had taken over his practice was to give back any patients that he had or had received. In our case, I was to go back into the office that I had left. I communicated with Dr. Anderson, who felt that we could work together with my taking over an office here, and he'd look after some of my patients if they had to be hospitalized in Reno.

As it turned out, the Industrial Commission was interested in getting more

space, and Dr. Ross moved his office from there over to the corner of Curry and Musser. With it went the State Board of Medical Examiners files. When I came back, I had to find a place to practice.

The old Odd Fellows Hall, which was a two-story brick building, and the Senator Club were in there where the Bank of America is now. Just opposite the Capitol on Musser Street, there were two apartments. You've probably heard of Ken Johnson; he was a state senator here for many years. Ken Johnson owned these buildings, and he rented one to me. It was sort of an inadequate affair, but it worked out all right. Had a reception room where you came in, and then I had a little consultation and examining room, and then a laboratory where we did blood counts and urines until we got the hospital in. I got a 100 milliamp X-raying unit. That was the first thing that we got here. I came back in the last of '46 and was there until '50, I think it was. Then I bought a house that was opposite the Capitol off Fall Street, the street that did go by the south side of the Capitol.

Who were you in practice with then when you first came back after the war?

Dr. Hovenden and later, Dr. Grundy. Kennecott Copper in the later forties, early fifties started to close down; they had their smelting works in McGill. Dr. Hovenden practiced in McGill for many years. In fact, Dr. Hovenden was a past State Medical Association president, I think, way back. Dr. Frohlich and Dr. Bowdle were in McGill, and they all went various directions, and Dr. Hovenden came over here. He was doing internal medicine.

A couple of years before that, Dr. Grundy had come through here as an Eli Lilly detail man. He said one day when he came, "Well,

I'm going to medical school." He says, "Maybe I can come back someday and see you."

I said, "OK," and we kept in touch with one another while he was in medical school.

After he graduated, finished his internship, he came here; and at that time Dr. Hovenden was just about ready to quit practice. But he said, "Why doesn't Grundy come over with me? We'll all work together — separate offices and so on."

Would you describe your routine in practice then? What was your day like?

Well, a day after the war I wouldn't have office hours in the morning. I'd head to Reno, to Washoe Medical Center or Saint Mary's — I was on their staff — and would make rounds there. I'd come back through Virginia City, Silver City, Gold Hill, make house calls on the way down, and get in the office about one o'clock in the afternoon. I was in the office from one until six.

Sometimes I would be interrupted with an emergency of one sort or another, or I would have to go to Reno to deliver a baby. Sometimes at night I would have to go in also, so that it was a tiring grind. When we got our hospital here, it was very much a relief, but before that we worked that out pretty well. Most of the deliveries were done there.

They had plenty of time to get there?

Yes, yes, yes. I had one experience where I had a baby in the back seat of my car, but . . . [laughter]

Were you transporting the mother?

Yes. This was before I was called in to the service. I had an Oldsmobile at that time that had the first Hydra-Matic shift in it. Reverse

on the shifter was down at the bottom. Well, this was the sheriff's wife. His name was Harold Brooks.

I think this was her fourth baby, and she called me up about two o'clock in the morning and said, "Doctor, I think I might be going into labor." So I said, "Well, I'll come down." I checked her, and I felt we could make it to Reno.

When we got out opposite Steamboat Springs, I said to her husband, "I think I'm going to have to get in the back seat and deliver this baby," because she said she thought it was coming. I carried at that time a little "OB pack," as I called it, in case I needed it. Her husband got in the front seat, and, thinking he was driving a conventional shift, he put it in gear, which on that car was reverse. When he stepped on the gas, we backed up and went down in the ditch.

Oh no! [laughter]

At any rate, we got out of it all right. We eventually got into Washoe Medical Center, but I delivered the baby in the back seat of the car while he drove us there. Fortunately, I had everything that I needed there. [laughter]

After the war, the major interest as far as I was concerned was to establish a hospital here in Carson City. Dr. Anderson and I were up on the Glenbrook golf course one day having a little golf session. Major Fleischmann, of Fleischmann Yeast, used to come up here to Glenbrook, where he had a home. During the summer months, because they didn't have a lot of Highway Patrol, they'd deputize him to look after that area up there. Well, he was down there on the golf course, and he called us over — Dr. Anderson knew him quite well — and he said, "I have been seeing quite a few accidents

around here.” He said, “Can’t we get a hospital in Carson City?”

I guess he previously had been approached, and that just was enough to start things off, and we said, “Well sure.”

He says, “I’ll put up half if the community will put up half.”

So all the service clubs and various community organizations got together. We started having benefits for this and that and the other thing with the idea that the money we raised would be matched by Major Fleischmann. Roy Whitaker at that time was chairman of the fund drive. Later it was Ella Broderick, who became Ella Wilson; she had the Old Corner Bar. Ken Johnson, our local senator, was involved. Everybody got together and we raised — I’m not sure of the exact amount, but it was enough that we felt that we could maybe start something.

Joel Snyder, who was with the Sprouse-Rietz Company in this region, had an architect that had built him something down in Tonopah, and we had free architectural services from him. We got an estimate on what it would cost, and we were pretty near to the figure, so we started it. Well, it happened to cost a little bit more, but Fleischmann came through with the rest of it. We built on Fleischmann Way and Mountain Street there, and opened in 1949 with twelve beds. As the years passed, whenever we needed anything like a surgical bed or incubator or anything of that nature, he helped. After he died, he had established a board called the Fleischmann Foundation, which was to distribute funds for charity. They contributed to many such projects, including UNR. They gave us a certain amount of money every year to improve things and so on. The Fleischmann Foundation over the years really helped out tremendously.

We had Dr. Hand, Dr. Thom, Dr. Ross and myself as the original physicians. To acquire

the necessary consultants, since we were all general practitioners, we called on people from Reno to come over and consult with us. Dr. Anderson was one of the surgeons; Dr. Miles was a urologist; Dr. Claire Wolf was obstetrics/gynecology. We also had a consulting radiologist and a pathologist. At any rate, we built up a consulting staff from Reno who came over periodically, and we held clinics at the hospital. Shortly after we got the consultants, we enlarged the hospital with a surgical wing, and we did quite a little bit of surgery.

Carson-Tahoe Hospital grew. As time passed we accumulated more and more doctors as the town grew, and we finally developed our own consulting specialty staff. Now, I guess, out of maybe a dozen doctors to begin with, with consulting staff, we now have over eighty consulting staff and regular staff.

We started out as a private, non-profit hospital, because all the people that contributed here were considered stockholders in a community hospital. They didn’t ever expect to get their money back, but at any rate it looked good to see their name as a stockholder. During Keith McDonald’s regime on the hospital board — I’m not sure of all the particulars — we were saddled with a lot of things that ran the hospital close to failure: highway accidents, indigents of one sort or another. In order to keep the hospital going, they made a city/county hospital out of it.

You were in a solo practice for eighteen years.

I was a solo practitioner from ‘41, with the exception of the years I was in the navy, until 1959 or ‘60, when Dr. Grundy came. At that time we started a group practice, known as Carson Medical Group.

Some other doctors had come to town: Dr. King was a surgeon, and Dr. Stewart was

a general practitioner. Dr. King practiced by himself, but was a consultant to us in surgery. He rented space from us in the Carson Medical Center, so then we were all together, and the medical community was together there, more or less.

How did solo practice differ from group practice?

Considerably different. In a group practice, you have other doctor's records available, and you can take calls for them. You alternate calls, let's say at night and on weekends and vacations. Consultations — you can generally have curbside consultations with each other and so on. It's of mutual interest to both. It helps your education a bit then to consult with others. In a group like that, it doesn't cost the patient anything.

Another aspect of it that is particularly good is that you do have some time off, and your practice is covered. In a solo practice, you're on call twenty-four hours a day, 365 days a year. It's a tough life. At least it was in those days. I seldom got a full night's sleep.

One of the other things that other physicians have mentioned in connection with being in solo practice, or in choosing a field where they had to be on call, for example, OB or general practice, was that it was difficult balancing family and their job. They spent so much time at medicine. Dr. Grundy was talking about working a hundred hours a week.

I never logged my hours actually. My usual routine was to get up and go to the hospital about 7:00 to 7:30 a.m. Sometimes I came home for lunch, and sometimes I just had a sandwich or something at the hospital. From there, I went on to the office in the afternoon. If there were any house calls to be

made, I made a few of them then. They don't make house calls anymore, but we made a lot of house calls in the old days. Sometimes your schedule was interrupted by an obstetrics or emergency or something of that nature.

Seldom did I go to bed before midnight, and seldom did I get all the way through the night uninterrupted, because I had a pretty fair-sized obstetrical practice. They generally get you out in the middle of the night, if you let Mother Nature handle it. Sometimes doctors, which I always called meddlesome obstetrics, broke the bag of water, and induced labor of some sort when it wasn't necessary. At any rate, if you let Mother Nature take its course, it's a rather trying experience.

I would say that if I had it to do over again, I'd try to form a partnership with someone or be in a group. It's a tough life to practice alone.

You mentioned house calls and the fact they're not made anymore. What has changed that people don't make house calls anymore?

Well, one thing is the technical advances in medicine. If you're called to see somebody, the old-fashion way of forming a diagnosis was by physical signs and symptoms. You went over a patient, and if they showed certain physical signs of an illness, and coupled with the history, you made a diagnosis, and treated it accordingly. Now to properly make a diagnosis, you go and get a blood count; you get an X-ray of the chest. You do a lot of other technical things that requires something more than a house call. Now many people, if they get something wrong, head for the emergency room. In the early days they came to the office, if they were able to come. And if they weren't, why, you made a house call.

With the change in the practice of medicine, do you think that the physician has lost something as far as observation because of the technology?

I'm sure of that. My dad was a diagnostician. He didn't have all the fancy equipment and so forth that they have now. In the old days the doctors made a diagnosis according to physical diagnosis — going over the patient with a history and their physical signs and symptoms and so on. They tied them altogether and came up with a diagnosis; it was generally pretty well on the beam.

Just from observations that I have made, with the exception of some doctors that I know that are real thorough and really counsel their patients, the average doctor now is just too busy to make any real personal contact in laying on of hands and sitting down and discussing things with the patients. They're too busy. They come up with a diagnosis, and they prescribe, but they don't get involved. Let's say they don't get involved emotionally; let's put it that way.

Do you think that this is healthier for the physician not to be so closely involved? How do think that works?

Well, it's changed a lot. Our big problem is just too many people in our world today. In the old days, the doctor was the confidant to the family and gave them advice on any number of different problems. He knew their history, their mother, dad — it was a just a family counseling job, you might say. He had a few antibiotics or specific drugs that he could use, but generally when a person was ill you more or less gave them supportive therapy, not specific treatment, because you couldn't. You didn't have a lot of the knowledge that we have now and the technical advances. So the doctor was a confidant, you might say, and looked up to in the community. Nowadays I don't think that the average person looks up to a doctor.

You stayed in clinical practice until 1971?

That's right. I worked with the Nevada Industrial Commission at that time. I did go to the office for about a year following to just catch up on some old patients and so forth, but generally I had to spend most of my time working at the Industrial Commission. So I just retired from clinical medicine at that time.

How did the job with the Industrial Commission come about?

When I first came here Dr. A.J. Hood from Reno was their consultant. Then, during the war, Dr. Thom took over as their medical consultant. They had commission hearings every Monday morning, at which time injured workmen would come in after they had apparently recovered, and they would be evaluated for any disability, as they called it then. Their claim would be closed and settled for a certain number of dollars.

When Dr. Thom began having failing health, I was called in occasionally, and I got acquainted with several of the people there. It was interesting work, and I decided that I would give up the long hours and get an eight to five job. I guess I was sixty, a little over, at the time, and I decided that I couldn't keep up with the young guys. I mean we shared our calls, but I just felt I couldn't keep up with them. Dr. Grundy and all the partners that I had were fifteen to twenty years younger than I, so then I decided that I would just go into an eight to five type of job, mostly an administrative job, with the Industrial Commission.

I didn't lose contact with medicine, because I was supposed to be sort of a liaison between the medical community and the Industrial Commission and establish good relations with them. I think we did. Prior to my work with the Industrial Commission,

there was no rhyme nor reason to what the residues of an injury were worth. About that time, the American Medical Association had a special committee to investigate this, so they came out with the guides to the evaluation of permanent anatomical impairment. It was an objective way of determining how much of an anatomical impairment a person had following an injury. Then, it also was defined as only a medical determination; if we wanted to get into the factor of disability, a disability was a combination of the anatomical impairment plus the other factors which would equate to a disability. The other factors would be the age, the education, the vocational adaptability of a worker who couldn't go back to his former work and so on, and all of that had to amount to a certain number of dollars.

That's where the trouble started with the Industrial Commission. The attorneys got a hold of that and got into the other factor business, and they pushed it sky high. There was no rhyme nor reason to that aspect of it; it was just how much they could get and put in their hip pocket, and the claimant got very little out of it. At any rate, the anatomical impairment was very objective. So, I initiated that, and that's about the only thing that I can say that I enjoyed about it. The rest of it was appearing in court and trying to argue with attorneys.

I don't have much use for the legal profession in that regard. These personal injury attorneys — they're not interested in social justice at all; they are interested in what they can put in their hip pocket. You see them on TV all of the time.

Did you have a lot of fraud on the part of the injured workers?

Oh, yes, that is one of the things that you were supposed to do, to review files.

Occasionally you would run into doctors that were not intellectually honest. They would not necessarily pad the bill, but they would do procedures that were not necessary. For instance, let's use back surgery as an example. We just got into argument after argument with various neurosurgeons and orthopedists doing back surgery unnecessarily. I understand that right now, the commission is under some sort of a program where they are managing patient care more carefully.

But it's true that a doctor will do a good surgical job, let's say on the back, but many times after surgery the patient was in just the same position they were before or maybe worse. That was primarily because there weren't true indications for back surgery. We tried to counteract that by referring claims that were requested for surgery to the University of California for a comprehensive, integrated work-up. Time after time they would determine that this surgery isn't necessary and they would recommend this type of program and so on and so on. Except for that, I enjoyed working with the commission. I don't like to butt into another doctor's method of practice, but some doctors are just not intellectually honest.

Did this come as a shock to you?

Well, yes and no. When I was first on the State Board of Medical Examiners in 1941, as I recall, we had a medical practice act, but it didn't really set down any particular standards for medical care. You had to be a graduate of an approved American medical school, a grade A medical school. But in the early days when they didn't have any particular regulations, we had some doctors in Nevada that came in with the mining booms. Their credentials were not as good as they should be and would be in later years.

When you consider human nature, there are bad apples everywhere, and I'm not talking about the medical profession in general. I'm talking about a few of them that were really just, you might say, robbing the Industrial Commission.

Was there anything you could do about that, other than refuse a procedure or something?

Yes, we reported to the state medical association; they have a grievance committee. Now, here again, the doctor we are talking about might be on such-and-such medical staff. His credentials are good, he's got friends here and friends there, and they don't want to get mixed up with it. So, until we get a good policing force within the profession itself, that will go on, I think, although it's much better than it used to be.

You went on the Board of Medical Examiners in 1941, I believe.

I went on the Board when Dr. Anderson left. Governor Carville appointed me to the Board to take Dr. Anderson's place.

I was on there from '41 until '43 when I went into the navy.

Then you were on the Board again from 1961 to 1969.

That's about right; I resigned from the Board feeling that there was a conflict of interest. I was doing a lot of work with the Industrial Commission, and I was reviewing claims of various doctors in the medical community, and I felt that I was wearing two hats and that I shouldn't be doing that. When I resigned, they appointed Dr. Grundy.

You mentioned that the Board of Medical Examiners, in its early years, didn't really have

money to do much investigating or prosecution. Was there basically only the examination process to try and determine the bad ones and get them before you granted them a license?

There was an investigative process with each one. They had to have proper credentials, and then we tried to find out something about their background, from whence they came. So, we wrote to the AMA and their county society and various other places where we might obtain information as to their character and competency and all that sort of thing. Whether they had been in any other problems of that nature. So that when we licensed them, we were reasonably sure that we were licensing a creditable individual.

In the early days there were some shady characters, Nevada being sparsely populated and with the gambling and a whole lot of other, as the rest of the country looked at it, shady activities. They felt that they might be able to get away with something here, in Nevada, you see. But we didn't have money to really investigate thoroughly or to prosecute anything in those early days. I think our reciprocity fee was a hundred dollars, and if they took the written examination, it was twenty-five. Most of the doctors that were on the Board had a per diem allowance, same as other state employees. There was very little that we could use to investigate or prosecute anybody. Generally speaking, I think some bad apples got into the picture early in the game.

What was the licensing examination like, the oral examination?

We had a written examination and an oral examination. The various members of the Board would give one or two questions for them to answer on the written examination.

For the oral examination we met with them and asked them questions about their training. After that, we asked them other pertinent questions; some of them were trick questions just as a matter of checking. Many of them that came in were well recommended with good credentials, and we were always interested in their ethical approach to medicine as much as their intellectual credentials. A lot of doctors were not very ethical that were moving into Nevada.

How could you test someone's ethics? What kind of questions could you ask?

Well, we usually got letters of reference and checked on those, but it's pretty hard to pin somebody down as far as their ethical conduct is concerned. We would give a hypothetical medical problem that could be debatable as far as treatment goes and see how he would do it. Sometimes it would border on questionable treatment, you see, but you had to have pretty good objective evidence to refuse somebody a license.

Was it a pretty nerve-racking experience for the prospective licensee?

No, as a rule, as far as I was concerned, most of them came with good recommendations from their school, from the communities. If they left a particular community, they would have an influential person, usually, write a recommendation for them. Most everyone that we had, as far as I was concerned, was ethical and honest and intellectually competent. We had to delve into those areas.

Did you see a difference between the function and the behavior of the Board from the 1940s to the 1960s? Essentially twenty, twenty-five years later?

Oh, yes, in the old days, when I first came, we had old-timers — there was Dr. Roantree in Elko, Dr. Bowdle in Ely, Dr. Slavin in Las Vegas, and Dr. Anderson in Reno; and all of them were more or less old-timers, more or less native sons, you might say. Most of the doctors that were coming in at that time were recruited by people they knew, and they more or less were licensed before they ever took an exam, you know, because the community was small. Las Vegas was just a cow pasture when I first came here, and everybody knew everybody, and it was just a matter of meeting them because you had to do it for the purposes of procedure. As time has passed and we've gotten more population, more and more applicants, why, things got a little bit stricter.

Do you think the small town character of Nevada made it easier to police physicians?

Well, I think I would have to say yes on that, because the more people you have, the harder it is to police. It was like a big family in those days.

In the 1940s, you wouldn't hear the term substance abuse. But there were doctors that drank, and there were doctors that abused drugs.

Oh, I think that would be one of the more common abuses when I first came here. That was characteristic of medical meetings and social events. Doctors all partook of spirits pretty well, and, of course, in those days there was not enough to give a lot of coverage, you know. Now, if you're not on call, well, you can go out and have a good time and forget about it, but there just wasn't the coverage then.

I don't think there was much in the way of narcotics abuse or anything of that nature; but

I can understand how there would be alcohol, because alcohol flowed freely in those early days, as it still does. I don't think the younger generation are as abusive as the old-timers were. I think because the younger generation is more — oh, let's put it this way, drinking lighter alcoholic beverages like beer.

No more three martini lunches.

Yeah, yeah. [laughter]

In the Board's records, they tended to have physicians whose names were coming up repeatedly. The Board would censure them and warn them, but they seem to come up time after time after time, become familiar names.

Most of those cases, in my experience, you didn't change their behavior; all you did was put them in a different environment — a more or less a supervised environment. They had to practice within a certain hospital or something of that nature; they weren't allowed to go out on their own.

I suppose I'm sort of in the old school, but I don't feel there is a good prognosis for most of those people, for a cure. There are those that have straightened out, but I wouldn't want to have a doctor that was an alcoholic or someone that's on some sort of drugs. I think if I were doing that, I'd put them under strict supervision, let's say a University setting or something along that nature, so that they wouldn't be on their own. But, you know, there are lots of opinions; I'm more conservative than liberal on most of these things.

Do you think that medicine is such a high stress career, that maybe doctors are more vulnerable?

It used to be a high stress field, but I think nowadays it's not. Doctors don't put the man

hours in that we used to. I think that some of the more meticulous surgical procedures that they have now probably may be more stressful.

I don't know. I had a patient here in Carson that had what is known as coarctation of the aorta. This was in the early days when they were doing some vascular surgery. I accompanied them down to the Bay area. A couple of the doctors down there removed the coarctation area and brought the two ends together with a graft. In the course of that event, the patient had something like twenty pints of blood. It was one of those things that was stressful to me just watching it. Some of surgery done now would be somewhat of an emotional stress on the doctors doing it.

It's stressful in that type of work, but, generally speaking, I think doctors have it easier now than I had. I am just guessing at that now, based on what I have observed. If you practice in a group, there is less stress than if you practice solo.

I believe that most physicians are in some sort of group now.

Yes, that's right; I understand that. In fact, I thought many times, if I had it to do over again, I don't know that I would choose to do as I did, solo practice versus group practice. I feel that group practice gives more freedom. My family grew up, and I was not a father or a husband, really. I was gone most of the time.

In talking about the Industrial Commission, you said something about finding physicians that were not necessarily honest in their approach. Working with the Board, did that alter your perception of your fellow physicians to certain extent?

Yes it did. I would mention something like that to the Board members and — well,

at that time we just didn't have the finances to investigate. Here I was, going in with a complaint and a few cases that I had documented as to what a certain doctor did, but the other guys on the Board were not anxious to do anything about it because he was a member of the community in which they were practicing. We didn't want to get into a big legal hassle because we didn't have money. But that was in the early days. Now . . . now, they are doing a lot towards maintaining standards in ethical matters.

We did not have a whole a lot of applicants, and, as I mentioned, got about a hundred dollars for reciprocity and about twenty-five for a written exam. Well, you can't do a lot of policing with that sort of thing. We had one attorney, and with the advice he gave us, he was always trying to steer us away from the legal aspects of it because of the cost.

That was Bryce Rhodes?

Bryce always was on the conservative side. He wasn't gung-ho about getting into court, and this was partly due to the money. We just didn't have the money.

Essentially the function of the Board is to protect public safety. How well do you feel they fulfilled that objective?

In the early days, I think there was something to be desired in certain areas. I think in Reno — and this is just in my time — we've always had good, intellectually honest, ethical medicine, generally speaking. It was a different story in Las Vegas. We had a lot of border-line practitioners, as I looked at it, but that was along with the environment. Now I've got a lot of good friends in Las Vegas that would back me up on it.

But now I think southern Nevada has evolved to the point where they have very good medicine. They've got post graduate hospital training facilities there with the primary medical school up here. They've got good residency programs down there. So that I feel that — just from my observations, I haven't had any personal experience with it for a number of years — I think that the medical community is now really quite ethical and up to standard.

Do you think the Board made a contribution to that?

I sure do. In the early days, I don't know what you would find in reference to early State Board of Medical Examiners, but I came on it in '41. The Board met four times a year. There were five doctors on the Board, representatives from the various sections of Nevada. If we were going to give a written examination, we would write out a couple of questions, and each Board member would do that. Then if they wanted an oral examination by reciprocity we would interview them.

In those days we didn't have too many applicants. Most of the applicants were friends or relatives or acquaintances of doctors that were already here, and so actually there wasn't too much that we could say that was derogatory or, rather, I always want to say unscientific. But it was a reasonably good Board.

As we got along in later years, in order to enhance the Board's image and to improve the status of the Board of Examiners, we joined the national association, the Federation of State Medical Boards. That was done during my second term. We would go back to Chicago, usually the Palmer House, and catch up on all the latest things with reference to medical licensure, and talk about ways to bring about

changes in medical licensure that were a little more non-political and more scientific.

I believe that in later years this has been accomplished. The Board of Medical Examiners is now much better organized than we were in the past and more scientific, I would say. In the old days, somebody brought a friend in, why, you passed them more or less because they were a good friend. You didn't really get into the examination aspects the way they probably are going to do now.

Would you see bringing in a friend as someone who comes in with a personal recommendation, and you're probably getting a good fellow, or is it an opportunity for somebody to slip in possibly who is not up to standards?

Well, in those days we didn't have much problem with that sort of thing, but I can see you might have it now. The Board, at least when I was there, could interrogate them in such a manner that you could pretty well tell whether you were getting someone that was a credit to the community or wasn't too good. And you could always find some way in which you might say, "Well, you'll need a little more training in this aspect of it." Or something of that nature.

I don't know, I haven't been on the Board since the late sixties. So it may have changed some. It was very informal when we had it.

Did that fit the times, do you think?

I think it did, yes, because Nevada was quite informal in those old days. You know, there was not a hundred thousand people here, in the whole state.

How do you feel about the future of medicine? Do you think a lifestyle has passed that will never be regained? Do you mourn the passing

of what medicine was, or do you look to the future and think, "How exciting"?

Well, it seems to me that medicine is progressing to the point where we are prolonging life— and I'm talking about something now that's sort of a sore subject with me — I think we are prolonging life unnecessarily, which adds to the cost of medicine. Maybe I'm just old-fashioned. But as we look at these various specialties and their ability to prolong life, there's got to be some criteria established that will not prolong life unprofitably.

It's a matter of dollars and cents, really. Just as an example, why should we do a surgical procedure, one of the more complicated ones, to preserve someone's life to a wheelchair, where they may not ever be able to maintain activities in daily living? I feel that in order to bring medicine to the point that we can afford it, we've got to set — I'm trying to think of the word — priorities. I think that if a person is unable to maintain his activities of daily living by himself, he should not be given any particular special, special care unless the process can be reversed. And in some cases, I think we are trying to reverse them unnecessarily.

Let's just use an example of a sixty-five year old person that needs some sort of heart surgery. If he or she can be guaranteed a productive life beyond that, I would say, "Fine." But if we can't, because of other systemic problems like bad kidneys or some other medical problems, we shouldn't be doing it. We should make them comfortable and more or less let Mother Nature take its course. In other words, we shouldn't allow anybody to suffer, but why do extensive surgical procedures or do dramatic procedures on people that don't have any life expectancy to speak of? If they can afford it, I'd say, "Yes." But

why should we have government do it? And that's where we might be heading in terms of more socialization of medicine.

Perhaps I'm just too old-fashioned, but I feel that we can't afford to give everyone one hundred percent medical care. You've got to call a point where you don't do any dramatic medical procedures; you just keep them comfortable. However, it's a question that's really, I suppose you might say, a very emotional one. Because all of us want to live as long as we can — that's just the nature of things. But we've got to call a halt to certain measures prolonging life. As I look at it, we are endowed by the Maker. There's a time, as it says, to die, and we've sort of interceded with Mother Nature. But I think that we better re-evaluate our procedures for prolonging life. By the time I come to the point where I can't function, I don't want to live. But a lot of people are preserved in a dependent state through dramatic procedures of one sort or another. But I'm old-fashioned, I guess.

Have you always felt this way?

Yes. I suppose I might be more conservative now as I've gotten older, but on the other hand, I've watched a lot of unnecessary things done in medicine that I feel were futile to begin with to inflate the pocketbook of somebody. But if everyone were to get all the medical care, both modern and life-sustaining measures indefinitely, we'd bankrupt the country. Just can't afford it. There's a time to die.

THOMAS SCULLY, M.D.

Dr. Thomas Scully was born in Jamaica, New York, and raised in New Rochelle. He attended Colgate University, where he received his B.A. in Biology in 1954. He entered Albany Medical College and received his M.D. in 1956. His internship was completed at Beaumont Army Hospital in El Paso, Texas, followed by a pediatric residency at the University of Pennsylvania in Philadelphia.

Dr. Scully was on active duty in the air force, serving in Torrejon, Spain, and San Antonio, Texas. After his discharge from the air force in 1966, he established a pediatric practice in Las Vegas for a year, then returned to the east coast, teaching at the New Jersey College of Medicine from 1967 to 1969. He came back to Nevada in 1969 to participate in the implementation of a medical school at the University of Nevada, Reno, and has been an integral part of that program since that time. He is currently professor of pediatrics, associate dean for alumni affairs, and director of the Medical Ethics Program at the University of Nevada School of Medicine.

*Interested in the issues of medical ethics, Dr. Scully received a grant to study medical ethics at the Hastings Center in New York. He co-authored a book on the subject, *Making Medical Decisions*, with his wife, Celia Scully, and has published numerous articles on the topic. He has been active in medical politics, both nationally and within Nevada, with particular interest in medical examination. He was appointed to the Nevada State Board of Medical Examiners in 1977, and with a hiatus from 1985-1988, has been active on the Board since. He is currently president of the Board.*

Thomas Scully, M.D.: I'm the youngest of seven children. I was born in Jamaica, Long Island, New York, in 1932. My father was about 40 years of age at the time, as I was the seventh child. My mother was 35. They actually lived in Poughkeepsie, New York, where he worked with an uncle as an automobile salesman. Matter of fact, it's interesting — he worked for my uncle, Dan Keyes, who used to provide Franklin Roosevelt and the Roosevelt family

with their Lincolns for years. We lived right near Hyde Park.

My father was Irish Catholic, born and raised in New York, as was his father. His family came from Tipperary, Ireland, in the mid-1840s.

My mother was a convert to Catholicism. She was raised as a Presbyterian in southern Illinois. All of her family, both mother's and father's side, were very early settlers of this country dating back to pre-Revolutionary War. They settled in North Carolina, Pennsylvania, and Delaware, and a variety of places. Most of them moved west after the Louisiana Purchase. I've done a lot of the family history and found that most of my mother's family migrated to Missouri and southern Illinois, arriving there in the 1810s, 1820s, 1830s.

My mother was a nurse, working at the Barnes Hospital. She had an interesting history. She worked for Harvey Mudd, of the famous Mudd family. The original Dr. Mudd finally was exonerated by President Nixon for having presumably treated John Wilkes Booth. Anyway, one of the descendants of that Mudd was a surgeon at the Barnes Hospital, and my mother was a surgical nurse. She was in Kansas City on a vacation in 1921, visiting a friend, and met my father on a blind date, purely by accident. Actually, a mistake. They were both staying at the same hotel, and my father thought this woman that he was going to meet for a blind date was my mother, and actually it was somebody else. But apparently they were attracted to one another, and after only knowing each other about six weeks, they decided to get married.

She converted to Catholicism and moved to New York with my father, to the chagrin of her family. Ultimately my grandfather and grandmother reconciled with her and my father, but for a number of years they were estranged. I guess that was one of the worst

things a Scots-Irish Presbyterian in southern Illinois could do — to marry a Catholic, an Irish Catholic, and a traveling salesman. He actually was a traveling salesman, and I think he worked for a subsidiary of Ford. He always was in the automotive industry. He traveled, selling, in those days, all sorts of automobile accessories.

At any rate, they got married, moved to New York where they lived for twenty-three years, and raised seven children. I'm the youngest. All are still alive except one older brother who died very young — he was only in his thirties when he died of a stroke. I'm not sure why, but the other brothers and sisters are all alive and well, and we've all gotten married and raised families.

Anyway, my mother'd had a couple of my older brothers and sisters at the Mary Immaculate Hospital in Jamaica, so she went down there and delivered me. We left Poughkeepsie and moved to New Rochelle, a suburb of New York City, when I was three, and that's the earliest memory I have, just preschool.

There were three older sisters and three older brothers. We were all raised Roman Catholic and went to Catholic schools, which was very typical of the New York suburbs in those days. That was the era of Cardinal Spellman and the development of Catholic schools. I went to Holy Family Catholic School for eight grades in New Rochelle, and then I went to Iona Prep School for four years, which was an Irish Christian Brothers' academy, also in New Rochelle.

My father died during the war, 1944. As a matter of fact, it was just fifty years ago in June. He died just a few days after D-day. He had been in the navy in the First World War and tried to get back in the navy when the war broke out in 1941, but at that time he had seven kids, and he was in his mid-forties, so he obviously wasn't accepted.

I have some recollections of my father, but I was only little — I was just about eleven years old when he died. My mother went back to work part-time then, nursing, and raised the rest of us. My oldest sister was twenty when my father died; there was about an eight-, nine-year gap between us. So my two older sisters were in college, and my two older brothers, of course, enlisted and went off and served in the military, and I was just a kid during the war.

So my father died in '44, but my mother lived to be 86. She died in my home just a few years ago here in Reno, so she lived a long life. I guess my mother probably had an influence on my deciding to go into medicine, although I don't really know. Only recently did I find out that my great, great grandfather had been a physician, educated in Edinburgh, Scotland; he then practiced in southern England for thirty or forty years. It was his son, Thomas, my great grandfather, who came to this country in 1844 as an engineer.

I married my childhood sweetheart. I met my wife in the third grade at Holy Family School; it was a Dominican school run by the Dominican nuns. We went to dancing class together in the seventh and eighth grade, and I took her to the movies. We dated, of course, in high school, and we dated in college, and we dated in medical school. Finally, we got married when I finished my second year of medical school. So, we've known each other a long time. We have five children, three of whom are married, and we now have four grandchildren.

Anita Watson: You said you had a Catholic education from the very beginning. Did all of the children go to parochial school?

Yes, all of us. All seven. My three sisters went to an Ursuline convent school where my

wife also went. One of my sisters became a nun in the Ursuline order, and then my three brothers and I all went to the Irish Christian Brothers' Academy. That was pretty typical of the middle-class Catholic community in many of the suburbs of New York. It was assumed that if you were a Catholic and lived in many of the suburbs of New York, that you would go to a Catholic school, and so yes, we did that.

Was that a financial burden to put seven children through parochial school, or were the costs reasonable?

They were probably unreasonable. As a matter of fact, that's interesting, I hadn't thought of that in a long time. My mother, I think, probably bartered a lot for our education, because I know she used to go and do private duty nursing and take care of many of the old, dying nuns and the old, dying Christian Brothers. During the war and even after the war, up until the early fifties, it was very difficult to find nurses. Most of the doctors and nurses had gone off to the war. She hadn't, I don't think, kept up. She wouldn't be called a modern nurse, but she had good skills. I can recall, even when I was in high school and after that, she would frequently put on her white uniform and go down to the convent, if it was the nuns, or over to the monastery where the brothers lived, and take care of the sisters and brothers, usually the older and dying people.

I never saw the details of school tuition. I was a pretty good student, so I got scholarships all through high school, and I got scholarships all through college. I also worked, afternoon jobs, weekend jobs. And in college, working in the kitchen slopping food and waiting on tables and all that sort of stuff.

Did your family emphasize education?

Oh, yes! Absolutely. As I say, I can't remember very much about my father, because I was the youngest, but certainly in our house education was the way to get ahead. We heard all of the usual post-Depression, middle-class kinds of truisms. You know, "Do you want to drive a taxi the rest of your life? You want to be a bus driver? You want to be digging ditches?" The only way into the middle class or out of being a blue collar worker was to get an education. That was strongly emphasized in my family, and it was always reinforced by my older brothers and sisters, as I recall, and by my mother. It was certainly reinforced by the Catholic church.

If you know much about the New York Catholic Church at the time, you'll remember that Cardinal Spellman was the guy that was building schools and colleges every time he could find a nickel. He was constantly asking for money. So, yes, education was very important, and it was always assumed that we would all go to the Catholic prep schools, and we would all go to college, and all of us did.

My father was alive when my sisters went to college. As I say, one went into the convent. She left the convent later on and got married and raised a family. All three of my sisters became school teachers, which was not uncommon in the late thirties, early forties. But my father, you see, up till that time was working and making a good income. We never suffered financially until he died, and he was always able to provide for my older sisters to go to school.

When my brother came back from the war, he went to school on the GI Bill. Of the rest of us, the youngest three: I went on scholarships, and I think my mother must have begged, borrowed and stolen or, as I say, bartered her services for the others. But it was

just assumed that we would go, and all seven of us went to college, and then four of us went on to graduate school. All three sisters have master's, and I have a doctorate. I am the only one that ended up in medicine.

What about a family network in your neighborhood? Did you have cousins, uncles?

Yes, but none of my mother's side. All of her family were back in Missouri, and I'm almost sure I never met my mother's parents. I might have as a little child, but I have no memory of it, because in those days you didn't get on a train — there were no planes — so you didn't get on a train and just travel to St. Louis. That was a big deal.

Most of the support systems were not so much blood relatives; they would be what we would call Dutch uncles, close friends of my father, business associates. I can recall calling several of my father's and my mother's friends "uncle," where they weren't uncles.

We lived in a nice neighborhood of single family homes. Most of the families in that neighborhood would be just like my mother and father, working people. Almost all of us went down to the local Catholic school, so the Catholic church and the Catholic school that we all went to really sort of became, in my memory, the focal point of social life, of friendships, of athletics, of Sunday church, of dancing class. Dancing class used to be held in the basement. After the war somebody got the idea that all these ruffians ought to learn something about how to bow: boys with a tie and a shirt and little girls wearing white gloves.

So the church and the school were focal points of our life, social life, education. As a matter of fact, I can remember — it sounds very parochial and silly to say it in today's world — but I can remember we were warned

by the nuns not to go into a church or a synagogue that wasn't Catholic. We ought to really avoid getting too close to "non-Catholics," and to avoid dating girls from the public schools. I can recall that somehow this was going to be the death of you to do any of that. So, it was very parochial, as I think about it. Very parochial!

But it was also very supportive for, in our case, a widow with seven kids. I can remember many of those Christian Brothers were serving as putative, surrogate fathers. In those days they didn't worry about corporal punishment. I got smacked a couple of times by one or another Christian Brothers, two of whom I still communicate with. I just sent a Christmas card to one of them who I've loved for years. He's a man in his eighties, and he sort of was the surrogate father for a couple of years. If I didn't do my homework, especially Latin homework, or didn't do something that I was supposed to, he'd smack me or read me out. I didn't get smacked too often. But if you wisened-off on them or used a smart mouth, as a teenager, they'd let you have it. And if you didn't like it, take your kid out of school!

But also they were very supportive. I mean, geez, they would take you to the Yankee Stadium to a ball game, and they were there for the football, and they were there for everything. It was a mixed blessing, I guess, in retrospect. It was parochial, but very supportive, and that's my memory of childhood. I was very lucky with my brothers and sisters. I think we were a pretty close family and they were always very supportive and encouraging.

After my father died, my mother moved down the street into a smaller house, but in the same neighborhood. My second oldest sister, as I said, was in the convent. It was a teaching order, but at the time she was in there, she was in the cloistered section

and hadn't gotten out yet. Subsequently, she became a part of their teaching unit. Even then, as I recall, they did their teaching and went back to the convent, but they weren't permitted to socialize or come home.

My oldest sister got married when her fiance came home from the war. And my other sister — what did she do? Oh, she was in town. She was going to college at the time. A few years after that, my other sister, the younger one — the one who gave me that kidney transplant a few years ago — got her master's in education and went to work for Aramco in the British American Oil Company. She spent the next, I'm guessing, fifteen years in Venezuela, Indonesia, Iran, Turkey. She would go and teach school, usually on three-year contracts for the families of American engineers and well-diggers. After the war from the early fifties to the late sixties, early seventies there was a lot of activity developing all these oil fields. Of course, that was the period of time the colonial empires were being split up. She'd be gone for three years, then come home and spend two or three weeks or a month or two at home, and we'd visit. So for much of my growing up through high school and college and medical school, she was more or less gone.

My oldest sister was married. She was gone. The other sister was in the convent. So it was pretty much my mother and my two most immediate older brothers. We were reduced from a family of seven kids and parents down to a mother and two or three kids for a period of time. Finally, when the rest of my brothers got married, I was in medical school, and then about 1956, maybe the previous year, my mother sold that house. She went into an apartment, and then spent the next twenty-five years in an apartment, because with all of us gone, there was no need to have a house. She still had all of her friends, but then she

had a nice little one-bedroom apartment and lived there from the mid-fifties, I guess, until she came out to live with us in 1980 and died here in Reno. She died in '83 when she would have been eighty-six years old.

You said you went to a Christian Brothers' prep school for high school. What sort of emphasis did they have there in education?

Well, it was all prep for college. First of all, they had an entrance exam, so it was not an open admissions. The assumption was that everybody was going to graduate and go to college; I mean, there was no question about it. It was a set curriculum; I don't think there were any electives. Everybody took the same lock-step, because they had limited resources and limited teachers. So maybe at the senior-year level you could get one elective in, but basically we all took the same thing. We started out and had four years of math, including trig and solid geometry and that, and then we all had at least three years of Latin. That was required. And you had to have at least two years of either French or Spanish. Then, of course, English and history and social studies. They had some social events; I mean, there was a glee club or a choir and I guess a band.

Was it a boys' school or was it co-ed?

All boys. No, no, nothing — all boys in those days; we're talking about the early fifties. I started high school in '46 and got out in '50, and my wife went to a convent school which was all girls. The public high schools were co-educational, but Catholic schools were not.

So I graduated from high school in 1950. I was this kid with no money and had to go to college where I could get a scholarship. I had applied to Notre Dame and Fordham

and Holy Cross and Georgetown — all of the Catholic colleges where everybody applied. I was an average student, but certainly not the brightest, and I didn't get a scholarship to any of them. But Colgate gave me a scholarship, so I said, "Well, I'm going to go where I can go free. I can't afford otherwise."

Maybe this is an overstatement, but I think I may be the one or one of only two kids in my graduating class that went to other than a Catholic college. I mean, the assumption in those days was you went to Fordham, Notre Dame, Holy Cross, Villanova, Georgetown, Boston College, and that's where all my classmates went, who I now see at reunions. I think one kid went to Princeton, and I went to Colgate, and you thought that was going to be the end of the world, that somehow I was going to head straight for hell, you know, that I was a damned heretic or something.

Well, of course, now that's all changed, and Catholic kids are going on to Ivy League schools, but then that was not something that was encouraged. It was even frowned upon. I'm commenting as much on what Catholic education appeared to be at least to me in those days, as on my own personal life. It was a rigorous academic program; I think every single graduate of my school went to college, many with scholarships, because it was excellent education. We were grilled in the, what I guess you would call the liberal arts, what served as pre-college in those days.

Was there a division in education? If you didn't go to a college prep high school or a prep school, then were you shunted into a vocational school?

No. In my community there were two very good public high schools. Many of those kids I knew then, and have been friendly with since, went on to college. If you couldn't make the academic program in the prep school, yes,

you then went to the public school. They had very good college pre-academic programs as well, but that was also where you would go for shop and mechanics and mechanical arts and that sort of thing, for boys. Traditionally, then, girls would go and take the secretarial courses and learn how to type and take shorthand. Of course, there were no community colleges in those days; you either did that at high school and went out and found a job, or you went on to college. Those were the only two alternatives, I guess, in the fifties.

How far is Colgate from your home?

Oh, it's about a five-hour drive. I guess it's about two hundred miles.

Was it a big shift leaving this neighborhood where you'd been raised, this rather closed, close environment and going off to Colgate?

Oh, yes. Yes. As a matter of fact, other than going into New York City, God, I don't think I was ever west of the Hudson River. I never went traveling — had no money to travel anywhere. We'd go into the city to a baseball game, and, of course, my wife and I would date and go into the city on Saturday to the opera because you could get free opera tickets. In those days the Metropolitan Opera would give free tickets to high school students just to fill up the audience. Occasionally her father would get tickets to a Broadway show, or there would be a movie. At this time of the year [December], we'd go in on the train and walk the streets and look in the windows, go to Times Square. Maybe we were just naive, but I can't remember having any fear walking around New York City in the late forties and early fifties when I was in high school or even during college. We dated and went there all the time. Thought nothing about it. It was a

fifty-cent ride down on the subway, and we didn't think much about it. I would never do that now.

My sisters had gone to a college right in town. I guess I was maybe the first to go away to school, frankly. I hadn't thought about it. It was a different experience.

I went there on a scholarship, and I had to work. The first year I was working in the kitchen, slopping breakfast or lunch. I made beds and washed dishes and did the usual things that a lot of college kids do even to this day. We didn't have sororities, but we had fraternities and you'd wait on tables in a fraternity. I still had a lot of support at home. Every once in a while one of my brothers, who by then were married and had jobs, would send me money, or my sister would send me a check, so I'd have some money to go someplace. My wife and I dated all through college, but it was really seeing each other during the holidays — Christmas, spring break, summer — that was about it, other than calling on the phone and writing letters.

We wrote a lot of letters. It's funny, you don't see people write letters like we used to. People call on the phone or send a fax, but we wrote letters a lot. My wife still has boxes of letters, because she's a writer, so she used to write lots of stuff. Celia's mother kept all the letters she wrote after we got married, so we have all of the history of our five kids being born and raised, our experiences in Europe and the military. When Celia's mother died, she found boxes of her letters in the attic of her mother's home. We brought them back, and so she's got them down in the basement and someday may go through them. Not that anyone really cares, but maybe our kids or our grandchildren will be interested. The chronology of our life is really in my wife's letters to her mother beginning shortly after we got married in 1956.

Anyway, when I went to Colgate I was very naive. I mean, I had a good background. I'd done well on the New York state regents' exams, and, as I said, I had won some scholarships, so I knew I could compete. But I didn't know exactly what in. It was a small school; we only had twelve hundred students in the whole school when I went there. That would be about what? Three hundred a year, so maybe three hundred freshman when I got there. Now it's about twice that size, and it's co-ed. But when I was there, it was small and it was men.

I was rooming with two young fellows who apparently had decided that they were going to be doctors when they were three years of age. I never thought about medicine. I didn't know of any medicine in my family other than my mother being a nurse, but I had no role models of doctoring. I knew, of course, nothing about my ancestry at that time. My roommates said, "Well, we're going to take two pre-med courses in our sophomore year." One was a chemistry course, and the other was a biology course. I said, "Well, I don't know what the hell I want to do."

Most of us joined the ROTC, as much to stay out of the Korean War as to be prepared if we were called, because the Korean War began that fall, 1950. The president of the university called everybody into the big auditorium, and some guys, I don't know, ROTC generals or something, got up and talked about the Korean War and how nobody knew how long it was going to last. So a lot of us joined the ROTC, which turned out to be a good thing for me in retrospect. I thought, "Well, I'll finish college, and I'll probably go in the military, and I'll find a job or do something."

Anyway, I took these two pre-med courses, and I liked them very much, and I did very well. The guy in biology, God rest his soul, who eventually got me into medical

school or at least encouraged me, Dr. Foster said, "Have you thought about going to medical school?"

I said, "No. I haven't really thought about anything."

He said, "Well, next semester why don't you take . . ." and he told me what courses to take. "If you do well, you might want to consider looking at medical . . ."

In the meantime, my two roommates who had already decided, began to influence me a great deal, and I've still been influenced by them all my life. One of them became the dean of Bowman Gray School of Medicine and is the vice-president at Wake Forest right now. We've been friends for forty-five years. So I more or less tagged along behind him, I must say, taking some courses. Part of it was aptitude — I had an aptitude for it — but really no overwhelming desire. All of a sudden I was in the junior year, and I found myself needing a major, because by then you had to be in a major, so I said, "Well, I'm going to major in biology. I do well at it. I enjoy it; it's interesting." I didn't like chemistry particularly, but I did very well in biology.

At the end of my junior year, Dr. Foster said, "I think you ought to take this new medical college aptitude test." They were just coming out with it then. Now all students take it; it's called the MCAT. But I think the MCAT, Medical College Aptitude Test, was developed after the war, in the late forties, early fifties. It was still a fairly new test.

Well, I did very well. And he said, "I think you ought to consider applying to medical school." I had no idea where medical schools were or how you applied. There were a handful of us, including these two roommates, who joined the same fraternity. I kept taking all these pre-med courses, and all of a sudden I applied to medical school, Albany Medical College, and lo and behold, I got accepted.

As I think back on it, I just sort of . . . must have seen it as some sort of an omen. Maybe that's what I was supposed to be doing. I told Celia, because we were talking about getting married, "We really can't get married for a little while."

She said, "I understand." So I was accepted, and I went.

Then, my sister who was the one teaching school in Saudi Arabia at the time, was very generous to me. As I told you, later she gave me a kidney, but at that time she sent me the tuition. She said, "I'll pay your tuition for the first year of medical school." She and I think one of my brothers sent me some money, and I borrowed some money.

It was now 1955 — the air force, the navy, and the army were hustling doctors. The Korean War was over, but they wanted physicians, so they started these various medical school plans. They still have them. We have students here in those plans forty years later. Anyway, I applied for the U.S. Air Force Medical Student Program. I think my record and participation in the ROTC in college, which was a good record, were probably helpful. Anyway, I got accepted to that program, and all of a sudden, I was on easy street. I was getting a lieutenant's salary every month.

As I told you, I had married my childhood sweetheart. Celia and I decided to get married when I was at the end of my second year of medical school — that was 1956 — so she and I have been married now thirty-nine years this year.

She went to college, and then when she got out of college, she worked in New York at the Rockefeller Institute as a secretary for a couple of years until we got married, and then she raised our family of five kids. When we came to Reno to get involved with the medical school in 1969, she went back to school and

got her master's in journalism here at UNR. She then started writing books. She and I have published two books, and she has published hundreds of articles. She's a magazines feature writer. I don't think she's ever worked as a working journalist for a newspaper, but she's written books and magazine articles, and we've collaborated on a number of magazine articles, and we've collaborated on the two books.

Anyway when we decided to get married, she was working as a secretary, and our first child came when we were seniors in medical school. With the military, I had enough money to pay all my tuition, pay off my debts, get married, and for the first time in my life that I can remember, I had some extra money to knock around. So, I essentially got my prep school and college education through scholarships, and my medical school education — with the exception of one year from my brother and sister, mostly my sister — from the air force.

I also had the help of my wife; like many medical students' wives, she worked and helped support us. It was because of that, that I obligated myself to six years of service in the air force when I got out of medical school and finished my residency. I was supposed to pay back six, and they let me out a year early because they had a glut of doctors.

How was medical school? You sort of fell into it.

I did. In a way, I think I did. It was not an urge that I can ever recall. I mentioned earlier that Christian Brother that I've always loved and respected, who was sort of my surrogate father. He told me, essentially, "You can do anything you want. You know, you've just got to apply yourself. You've got the ability. Don't waste your time; study hard and something will come along." In college I did do that. I

studied hard. I did very well, got good grades, and I sort of gravitated to what I obviously had an aptitude for. In applying to medical school, I said, "Well, if I get in, I'll go. If I don't, I'll do something else." Because I would have had an obligation probably to the air force anyway.

The first year, I think, was an absolute blank. I can remember almost nothing about the first year. One thing I can remember is starting in anatomy in a traditional anatomy course. In those days, they did not embalm the bodies. They had them in big vats of formaldehyde, so it was a very offensive, pungent odor, and you took your cadaver out each day from this vat of formaldehyde. I can recall this very vividly: the chairman of the department was a chain-smoker, and he said, "Well, anyone who wants to smoke in the lab, it's perfectly fine because it's such a smell." So everyone began to smoke, mostly to deaden your nasal passages. I'd never smoked a cigarette in my life, never was interested, although my older brothers smoked, and one of my older sisters, I think, smoked. But I took up smoking in the freshman year of medical school basically to survive the anatomy lab. Everybody else smoked; we just were constantly smoking to kill the odor and deaden our nasal senses.

Other than that, I can't remember much of the freshman year. I think there were periods when I wanted to quit, because it wasn't what I expected. I remember it being very harsh, being sleep deprived, constantly being examined, a lousy anatomy lab, not much time to develop any kind of friendships. We had classes — we don't have them that way here anymore — six days a week. We had classes on Saturday till one o'clock. So your weekend was really started about two o'clock on Saturday till Sunday night, and that was for studying or sleeping.

So I don't really remember much of medical school until my third year. I was an average student, and I really struggled the first two years. I had to repeat some exams. The first and second years I worked at night in the blood lab. For about six months I lived with a paraplegic who was a school teacher. He needed an assistant to get him out of bed and give him his baths and get him dressed in the morning. We'd get up every morning at 5:30, get him ready to go to school. He would be picked up by a transport service, and he'd go and teach school in his wheelchair. He'd come home in the evening, and I'd get back from school, and sometimes we had dinner together. I'd put him to bed at night, and then I'd study. For that I got room and board from him.

But I was always working, so it was a struggle to work, make enough money to survive that first year; although my sister gave me tuition, I still had to get room and board somehow.

But then, when the air force came along and I got married, all of a sudden I had some free time, some extra money. I really remember medical school for me beginning in the third year. And I did very well in the third and fourth year, won some prizes and received a lot of encouragement, because then I was out of the labs and the strict memorization and the science and that and into patient care and problem solving.

But my medical school education was pretty traditional. I think if you talk to most people who went to medical schools in the fifties it was similar. The first two years, you didn't go very much near any patients or hospitals. It was mostly anatomy labs and pathology labs and autopsies and cadavers and memorization and chemistry and that sort of stuff, with a little clinical stuff at the end of the second year. So I really remember

my third and fourth year as being medical school for me. I obviously had learned a lot in the first two years, but I can hardly remember the names of most of those professors. I can't remember much of anything.

But I think that experience, sort of a negative first two years and a very positive third and fourth year, had a lot of influence on me later when I decided to get into medical education and try to influence how doctors were educated. Of course, I was happier then. I was married to the woman I had loved for years; God, we'd known each other since the third grade and talked about getting married practically in high school. I mean, as far as I know, I was her only boyfriend and she was my only girlfriend, so we had known each other for years. So finally we were getting married; we were living together. She was working, and I was getting a check from the air force every month, and we could actually go out to a restaurant or to a movie, and that sort of thing. But the first year of medical school was about the toughest educational year that I can recall.

Even tougher than your internship.

Oh, yes. Oh, internship was fun. I worked hard, but I was taking care of patients. That's what you go to medical school for.

Where did you do your internship?

Well, I was in the military. Now I had a pay-back. But in 1958 the air force had no internships and those of us who were in the air force either went to an army hospital or a navy hospital. Of course, the army and the navy had had internships for years. Remember, the air force was only started as an independent group, by what, Eisenhower, I guess, or maybe Truman, late forties, early fifties, so the air

force was sort of just getting going. I think the air force opened its first internship at Lackland, maybe in '59 or '60, but this was '58. So, I was assigned to an army hospital, William Bowman Army Hospital, El Paso, Texas, and did my internship there.

Then, I decided to go into pediatrics. As I told you, I did well in my third and fourth year in pediatrics, and I had a lot of good role models. So I decided to go into pediatrics, and at that time the air force said, "Well, if you can get yourself into a civilian program, we'll sponsor you and you can owe us two more years. Or if you go to a military program, then it's essentially a wash."

So, I called around. The young fellow that had been my roommate in college, who had influenced me to go into the medicine, was doing his internship at the University of Pennsylvania. We were just talking as friends, and I told him, "Well, I've decided I'm going to go in to pediatrics."

He said, "Oh, you ought to consider coming to the University of Pennsylvania. They have a wonderful pediatrics here, one of the best programs. It's excellent. Why don't you apply?"

So I applied. Called the guy on the phone, the chairman and he said, "Well, I don't have any places."

I said, "It won't cost you a nickel, because I'll come free to you. The air force will pay my way."

He said, "Oh! That's different. Send me an application."

So I went to the University of Pennsylvania for those two years on an air force-sponsored residency. I was essentially let out of the air force, except on paper, for those two years in Philadelphia. I still got my check every month, but I never put on a uniform. At the end of my residency, I had to go back in and pay the piper, and I then owed them five years: three

for medical school and two for residency. So I put on my uniform, and we were assigned to Torrejon Air Force Base in Madrid; we went there for three years.

How was it in Madrid?

That was a wonderful experience. One of the reasons we went there is because they sent around a little form to fill out about where you'd like to go and why. I told them that I didn't know a thing about the air force, and I would like to talk to somebody about it. Some lieutenant or somebody I talked to in Washington said, "Well, if you want to come down on the train some Tuesday, I'd be glad to sit with you, and we can talk about what options there are." So I actually I didn't fill out the form. I got a day off work, got on a train, and went down on a Tuesday morning in the winter. It was in February, rainy and miserable. Got off the train and went to this guy's office in some building somewhere near the Pentagon, and he said, "Well, I want you to talk to this sergeant over here, because he's the one that makes all of our assignments."

And he said, "Oh, yes, I know who you are. Yes, you are getting out in July. Yes, you've got to be assigned. You're in for five years. Yes, you're a pediatrician. Yes."

I said, "Where are there opportunities?"

He said, "Well, let's look." So he pulled out his file card thing (they didn't have a computer in those days), and he thumbed through, and he said, "We need a pediatrician," and he read off all the places he needed a pediatrician.

I said, "Well, I'd like to go overseas."

And he said, "We need somebody in Turkey and somebody in Spain and somebody in (I think) Wheelers, North Africa and some other place in Germany.

So I said, "Well, I'd love to go to Spain if that place is available." When he asked why,

I said, "Well, my wife is Spanish, and she's fluent in the language. Her mother was born and raised in Spain. She has lots of relatives there . . . " which she did, aunts and uncles, and still does.

He said, "I can't promise you a thing, but let's go have lunch." So I went out and had lunch. I think I bought him a beer or two, and I caught the afternoon train back to Philadelphia. About, oh, I don't know, a month later, I got a letter saying I'd been assigned to Torrejon Air Force Base.

I frankly think this sergeant was the one who said, "Sure, well, this kid came, and he showed enough interest, and he has some family ties." They were concerned about things like that because at that time, this was 1961 now, there was always the concern about the "ugly American" wherever we were. I was a guy who had a wife who had relatives in Spain. Celia had visited there; actually she was one of the first people to go into Madrid with her mother after Spain opened up to tourists just after the war. I think 1945 or '46. Her mother went back to visit her brothers and sisters; the family had been separated — half in Spain and half in New Rochelle, New York — first by the Spanish civil war and then by the Second World War. So the family had been separated from 1936 to 1945, almost ten years. They communicated by letter, censored. We have lots of censored letters with big blocks censored out during the wars. So, my wife had been back on a number of occasions, and had learned Spanish at home. I think that's probably why we got assigned there.

I finished my residency in June of '61, and at that time we had three kids: a baby, and we had a two-year-old and a three-year-old. So we packed up and off to Spain we went. We spent three years there, had another child while we were there, and had a wonderful three years. I was a pediatrician along with

another one in a base hospital. We had maybe twenty-five or thirty doctors there. Several of those doctors ultimately ended up in Las Vegas and were the reason that I came to Las Vegas in 1967. But I am getting ahead of myself.

You treated base personnel. Did you ever work with Spanish citizens?

We treated all the base personnel and, yes, because that base was a joint base, Spanish citizens, too. It was run by the Spanish air force, and we were tenants. The American air force ran all the airplanes and the atom bombs or whatever the hell was there; the air force, the United States Air Force, built the hospital and the whole base, really. But there was never an American flag that we ever saw flying on that base. As you came into the base, there was a Spanish flag, and there were Spanish soldiers and American soldiers at the gate. They did everything they could to keep a low profile because of a lot of hostility in the United States towards Franco, who was still in power in those days, and a lot of anxiety among the Spaniards that somehow they were selling out to the Americans. Franco, as you well know, had remained neutral during the Second World War, although he got help from Mussolini and Hitler during the Spanish civil war. When the Second World War came, he remained neutral. Eisenhower opened the agreements that led to the base, but there was a lot of sensitivity to that. So, for example, the Americans, including those of us on the base, never wore our uniforms downtown. We would wear our air force uniform to work, and we'd wear our uniform to and from the house wherever we lived, but whenever we went downtown, we never were to go into a bar or restaurant or anyplace with American military uniforms on.

The base also provided for all the Spanish air force, and, of course, many of the Americans, particularly the young Americans, would marry Spanish girls shortly after they were there. A lot of my practice, because I was a pediatrician, were the babies and infants and children of mixed marriages — American air force to Spanish girls — plus a fair number of the Spanish dependents. Each of us was paired off in the hospital with a Spanish doctor. I've been friends with my partner now for thirty-some-odd years. He was trained in this country, but he was a Spanish national, and he and I were the pediatric department. We had Spanish physicians in OB and Spanish physicians in medicine, and we were all paired with Americans. In order to work there, all the Spanish physicians were fluent in English. But we, the Americans, were not required [laughter] to be fluent in Spanish, which was kind of silly. I learned enough to get by. I could ask a mother about her kid's diarrhea or cough.

It was a three wonderful years, but the economy in Spain was very bad then, so we arrived with three children, and you could get a maid to help to take care of the kids for practically nothing. We had a *chica*, they called them, who would come live in your house and take care of the cleaning for room and board. So Celia and I were able to do a little traveling, saw a little bit of Europe — not a lot, but we did a little.

And we made lifelong friends; we've been back to Spain six or seven times since. Celia still has cousins and aunts, uncles, and relatives in Madrid and all over Spain. Like many others, we got to see a lot of Spain through the eyes of Spaniards and their culture, and not as tourists seeing whatever the tourists see. It'd be like people coming to Reno and spending time in your house and my house as opposed to being in the hotel.

So it also gave us a fondness and a love for Spanish culture and Spanish things. Most of our home is decorated with furniture and decorations that are Spanish, because that's my wife's heritage.

The friendships have lasted. We've already put on a couple of reunions in the last ten years. We organized a big reunion in 1990, and we found, oh, somewhere around a hundred American physicians now practicing all over the country, who had been in the air force at the time, from '58 to '68. Not always with us, but in that period. We had a three-, four-day meeting and put on papers and had a wonderful social event.

That time in Spain was a big influence on my life, personally and also professionally. I had just left my residency, so this was my first foray into practice, to taking care of patients on my own. There was nobody to call for help. The Spanish pediatrician I worked with was senior to me, four or five years ahead of me, and he was good. He was really experienced; I learned a lot from him.

But the time in Madrid had an enormous influence on our personal lives: we had time to be together; our family was just growing; we had some extra money; we could do a little bit of traveling. I was maturing as a physician — I was getting experience, and beginning to get confidence in myself as a doctor. I don't care how cocky a physician is, I think most physicians down deep have anxiety when they get started. Will they be competent? Will they do a good job? Will they screw up? Will somebody die at their hands? Do they know enough...? There're always those kinds of things. I hear this from students and young doctors all the time. Some acknowledge it more than others, but I certainly had a lot of anxiety. So I recall Madrid very much like my last two years of medical school and some of my college experience, as sort of key points in my professional development.

Plus friendships. Probably the friends we made in Madrid for those three years have lasted longer than any others with a few exceptions. The kid in college I just mentioned earlier is one, and a few of my wife's friends from high school that she still talks to, but the people we knew in Madrid; we've remained friendly and still communicate. So that was a good experience.

Did you have any specific type of medicine that you practiced there, any medical challenges that were unique to Spain or unique to the military? Or was it just good preparation for a general practice in pediatrics?

There were only a couple of unique experiences. I'd say it was very much like it would have been if I had been on an air force base or army base anywhere in the world, taking care of Americans. Pediatrics is a lot of preventative medicine, so it's immunizations and growth and development, and reassuring mothers their kid's all right. But I had a number of experiences that were interesting and were part of my, I guess you'd say, growing up as a professional.

I was in Spain when the thalidomide epidemic broke out; I tell this story in the first part of my book. I had one of the first thalidomide babies, born to the wife of an American Foreign Service officer who worked for the embassy. She had nausea of pregnancy, and on a trip to Germany she had gone into a pharmacy and had gotten thalidomide in the form of Softinon. It was a wonderful anti-emetic, wonderful for women who had nausea and vomiting of pregnancy. The problem is that thousands of women took it for that reason, and, of course, in many European countries you could get it without a prescription. It wasn't in this country at this time. And so seven or eight thousand kids, as

you know, were born without arms or legs or lots of other things.

But the thalidomide was a unique experience, primarily because that was a European phenomenon. I don't think there were any thalidomide babies born in this country. If there were, one or two, but very few. So that was unique.

What happened with the thalidomide babies? Did most of them survive?

Yes, many of them died of congenital heart defects, but many of them did survive. The University of Heidelberg had a world-famous rehab program for years, where a lot of these kids, including a patient who I still hear from to this day, went and got artificial limbs. Most of them were born without arms; some were born without legs, and many of them had heart disease and other congenital defects. There was enormous development of prosthetic devices for armless kids, but there were problems with taking little babies and giving them something to use, and then seeing that progress as they got older.

There's a whole group of thalidomide kids who are now in their thirties. There was a program on TV recently about Canada, where they have a whole support group. Many of the kids with thalidomide eventually threw away their artificial limbs and learned to do fine with their toes and had other ways of accommodating. A lot of them did die, and frankly, I don't know the latest statistics. I think there were something like eight thousand worldwide — mostly in Germany and England and France — who were born. And it seemed to me that many of them were dead within a few years of heart disease, but a lot of them survived and are now grown men and women who have gone on and raised families.

It was a peculiar drug — it was a good drug in terms of its intended purpose, but it should not have been given to pregnant women. It's still considered a good drug for anti-nausea and anesthesia, but no one, of course, uses it; it's not licensed. There's some discussion I've seen in some of the literature of allowing it to come back into use as a pre-anesthetic because of its anti-nausea effects. As a pregnant woman, you had to take it in a very short window. I've forgotten when most women get nausea, but basically, as I recall, it would be somewhere around thirty-eight to forty-eight days. It was really in the first six weeks, and it was only a period of about ten days when the arms and the leg buds of the fetus are developing, where that drug had its devastating effect. Apparently, if it was taken later, it didn't have the same effect.

We tell this story in our book. One of the first big issues about abortion in this country was Sherry Finkbein, who had taken thalidomide. We didn't have amniocentesis in those days, and she was worried about giving birth to a thalidomide baby, so she went to, I don't know, Sweden or Norway — Sweden, I guess — to have an abortion. She couldn't get an abortion in Texas or Oklahoma; of course, it was another ten years before *Roe v. Wade* and all that got started. But she could get an abortion in Scandinavia, and that became a cause célèbre: the issue of therapeutic abortion.

There were two other experiences that I remember as unique. One I had seen because the air force took care of Peace Corps volunteers. Remember, Kennedy was in the White House; he was elected in '60, and, of course, he got killed in '63. The Peace Corps was in North Africa, and we took care of children and adults flown out of North Africa, so Madrid was the first place I saw malaria. And I saw leishmaniasis kala-azar.

Now, what's that?

That's a disease spread by — oh, God, it's spread, I think, by flies or ticks; I'm not sure. And I saw echinococcus cysts, which are parasites that are carried by sheep. But they were patients who were sent up to Madrid from north and central Africa, where their parents were in the Peace Corps. These kids would come down with something, and there was no medical treatment there. So they would fly them into Madrid for us to take care of. These were tropical diseases that I might have seen if I'd ever been assigned to someplace in Africa, but that I saw in Spain because of the circumstances.

So I saw some unusual diseases, and then we had a big outbreak of shigellosis, which is a dysentery. As I was telling you earlier, a number of the soldiers and the airmen, who were young kids, essentially, out of high school, living on very meager rations — they would live on the economy. Many of them were married to Spanish girls that they had met shortly after getting there. There was a little town near the air base where they didn't have much running water, and they used a central well, and that got contaminated. I must have taken care of, oh, about, without exaggeration, thirty or forty kids, who were brought into the hospital at the base in a period of two or three days. All with severe diarrhea, severe dysentery, due to a contaminated well. My Spanish partner and I and some other helpers were sitting there sticking IVs in these kids. We had — oh, what am I trying to say? — cribs up and down the hallway, wherever we could find space, with kids stuck into IVs, trying overcome their dysentery.

I also saw an epidemic of diphtheria in southern Portugal. I'd never encountered that before, not even in medical school. There were some Americans from the embassy in Lisbon

who had been exposed, and some sailors, and their kids, who were assigned to a naval base. I flew over and participated in immunizing a whole bunch of kids for diphtheria — the only diphtheria I've ever seen in my life. That was kind of interesting.

There was a time when I was flown by helicopter into a radar base up on the top of a mountain in northern Spain. There was a small cadre of air force there who had their kids with them. We had radar bases all over Europe, you know, on the top of mountains in those days. We had independent duty corpsmen in all these places. This corpsman called me on the phone and said, "We've got a sick kid," and he described it to me.

I said, "Well, it sounds like the kid's got meningitis. Do the following things, and I'll be there as soon as I can get there." So we flew up in a helicopter and picked the kid up to treat him for his meningitis. That was pretty typical pediatrics.

Those were the interesting diseases that I had never seen before and will never see since, unless I go to Africa or India or someplace. Of course, many of those diseases are even gone. But, no, I guess the rest of my life there was very much as if I had gone into practice in any other community, doing general pediatrics.

Who were the people, specifically, that you encountered while working in Spain? How did they influence your career?

Well, I would say two groups of physicians: first, were the Spanish physicians, all of whom were fluent in English and had trained in this country; maybe a few trained in England. Dr. Rubio, was the Spanish physician with whom I was paired for three years, and who was a mentor for me.

There were about, oh, eighteen or twenty American physicians in all specialties, about

eight or nine of whom eventually came to Las Vegas in the mid-sixties, which was a booming city: Dr. Jacobs, who is now president of the Board, and his wife, Parvin Modaber, both physicians; Dr. Knudson and Dr. Lum, radiologists; Dr. Armour, surgeon; and Dr. Harris, an orthopedic surgeon. There were a number of them. And they all sort of were attracted to Las Vegas, really at the behest of Ted Jacobs, who was the first. He and Parvin went there, I think, in '63. They started a practice in Las Vegas, and recognized that Nevada was going to grow and that Vegas was going to grow. We were getting out of the service, almost all of us were of the same age group, and almost all of us were in the air force paying back various educational debts.

At that time, there still was a Berry plan, named for Dr. Berry. He was a physician who worked for the government, who established a plan where physicians would get certain support while going to medical school, and then they would go in and practice in the military. I don't know all the details of that; I wasn't a part of that. Anyway, these eight or nine physicians, one after the other, beginning with Dr. Jacobs and his wife, Dr. Modaber, came to Las Vegas. I guess I was last to get out of the air force of that group, and I was the last one to come to Vegas in 1966. And so that's how I got to Nevada.

Well, these were all good physicians; they've proven through the years to be outstanding physicians in Las Vegas. I'm the only one, actually, that came to Reno. All the rest have stayed in and practiced in Las Vegas. Dr. Knudson's now dead. But the others are all alive; a couple of them have retired. Dr. Jacobs, Dr. Modaber, and Dr. Armour — they're still practicing there. So they were early influences I think also in what then became a burgeoning physician population in Las Vegas, which, of course, only coincided with the population growth.

They were, with few exceptions, very supportive of the early development of the medical school, and a number of them have their names on the plaque out there in the hallway, because they contributed money to the development of the school. Dr. Jacobs was one of the first physicians named to the advisory board of this school. Dr. Knudson served on the admissions committee for a number of years. Dr. Armour, Dr. Christiansen, Dr. Lum, Dr. Harris — Dr. Harris had a son who came to this school — they all at one time or another took students into their practice. So when I came to the medical school in '69, and we started in '71, I naturally called a lot of them, and encouraged them to help us in education of the students. The very first summer after the school opened, in the summer of '72, we started a preceptorship program. I took freshman students in that very first class, many of whom lived in Las Vegas, and put them into all these doctors' offices. So it was a very early contact between the practicing physician and the student in the school. Of course, we did the same here in Reno with physicians and with the students who lived in Reno. Even the students who came from rural Nevada, we'd put in physicians' office. So we've had a preceptorship program for the last twenty years or more. So they were, I'd say, influential in my professional development, bringing me to Nevada, supporting me and others in the school when it got started, and being role models for young students, because they're all very competent physicians.

A number of the physicians have mentioned that they came to Las Vegas because it was growing; there was a future there. At that time, was it part of that sunbelt phenomena? Was there similar growth in other areas like Phoenix

and southern California? Did you consider other areas?

Yes, as a matter of fact, I did, and I suspect they all did, too. I went to Albuquerque and looked at a job; I went to Modesto where I had a friend; I went to Fresno; I went to Las Vegas, of course. Didn't come to Reno then; I came to Reno when they started the school. I'd looked at several places in Texas. We were encouraged to stay right in San Antonio where I got discharged from the air force.

After Spain, we had come back to San Antonio for the last two years, where I owed my time. That was in a teaching hospital, so I got interested in teaching there, but basically decided I didn't want to make a career of the military. I'd gotten wonderful education from the air force, and I've been very grateful all my life. I paid them back my five years that I owed them, and then I got out. And, as I said, those physicians who I had met in Spain, who ended up in Las Vegas, influenced me and several others to come to Las Vegas in the mid-sixties when it was beginning to boom. Of course, it's been booming ever since, but in those days it was just starting, and there was a need for physicians. So I went into practice in Las Vegas in 1966, when I got out of the air force.

Celia and I were married about ten years by then, and neither she nor I had really had any desire to go back to New York. New York didn't need more doctors. But the West was growing, and there was room for young physicians, so that was a big influence. Celia still had family back there, and, of course, as I said earlier, my mother was there, and some of my brothers and sisters still live back there, the ones that are still alive. But we had no real desire to go back there. We had lived in the Southwest, in El Paso, Texas, where I interned, and we had lived in Madrid, which was very

southwest. It's a very high desert, very much like Reno — dry, warm climate, hot in the summer. Then we lived in San Antonio for two years. So those three experiences — a year in El Paso, two years in San Antonio, and three in Madrid — said to us, "We want to live in the Southwest, desert, dry climate. That's the life we want to have and where we want to raise our family." We didn't want to go back to cold, humid, wet New York; had no desire for six months of overcast, rainy, snowy, wet, and slippery weather in New York, or anyplace in the Northeast. We've been back many times to visit family, and every time we go, we say, "Oh, boy, are we glad we stayed."

Was climate the only reason you didn't want to go back to the East Coast?

Well, there were a couple of other things. One, I think the main reason, was my desire to be involved in something new developing. We had been raised in the East. It was traditional; they had lots of doctors; there wasn't the opportunity to move along in the profession as fast. So I think a lot of it was a pioneering spirit — that sounds kind of pretentious, but there was a desire to do something new and different in an area where there wasn't much tradition, where there weren't a lot of people saying, "No, you can't do it that way." That was one reason.

Secondly, I knew in most of the communities that I just mentioned, they needed pediatricians. They needed any kind of physician, and they were happy to see anybody come. Whereas another physician in the suburbs of New York usually said, "Oh, my goodness! What are you here for? We have enough of you." So it was that attitude.

Then, of course, it was just the simple ease of raising children in the Southwest. We had five by then. There was also a certain

desire, for my wife and I both, to be somewhat independent in the raising of our children and our family, without our families telling us what to do or what not to do and interfering. We had no great need to be near our families.

Don't you find that interesting, in light of what you told me earlier about having been in a neighborhood with a close sense of community, that you chose to leave?

Although it was a very large community, we found in many ways that we didn't want to live there and raise our kids. We would not have survived well in a small town, where people know all your business. So, yes, there is a paradox, I guess, when you express it that way. But we wanted to be on our own and do it our own way without everybody telling us, "Oh, you ought to join the country club" or "Why aren't you participating in the school fair?" or "Why aren't you involved in PTA?" or "Why are _____?" You know, you can fill in the blank. "Why aren't you doing something, because everybody else does it?" My wife and I are fairly independent, although we're very close and always have been. We didn't have any desire to go back and have to fit into somebody else's idea. Of course, there was turmoil, you know, in the sixties and seventies in the world, nationwide. But we perceived being out West and at arm's length, if you will, from all of that, as better for our own development as a family and as parents.

Do you remember your first impressions of Las Vegas?

Yes, I do, because we came on a recruiting trip, obviously, to talk to people and then moved four or five months later. So, yes, I do remember the first impression. It was very warm and very friendly because by then the

seven or eight doctors that I just mentioned and their wives were there. So we were immediately received by a very close family group who were desirous of us coming. We weren't coming to a strange town in that sense, and we certainly weren't impressed with the glitz and the public image. They weren't, either. This was just another community with lots of people.

You know, when you got pneumonia or bronchitis or a sore throat or a broken leg, whether you're a topless dancer or you're a gambler or a pit boss, you still have the same pain, and you still need the same kind of treatment. It doesn't make any difference who the hell you are, really. We weren't particularly turned off or turned on by the public image or the glitz of Las Vegas. We felt very accepted and warmly greeted. We almost made the decision that first night when we visited that we were going to come back; it was just a matter of working out the details.

What were the details of your move there? Did you go into practice?

Well, yes, I went into practice with Dr. Anthony Carter. He was a pediatrician who had been in town for a couple of years — a year or two older than I. Actually, Dr. Carter, subsequently, as you know, was a member of the Board of Medical Examiners. He served for about four or five, six years; I've forgotten.

Tony and I were in practice for a year, but that's when I began to be disenchanted with private practice. What I recognized then was that I really would be happier in an academic environment where I was teaching and being with students. I'd done that the last couple of years in San Antonio. I tried spreading my wings in private practice, and I really didn't enjoy it. I was a good doctor, but I just didn't enjoy it; that's when I left and went and joined a medical school faculty.

Was it more the desire to teach than the disenchantment with private practice? What specifically didn't you like about private practice?

I think I enjoyed the encounter with the patients and taking care of children who were sick, because I was a pediatrician. But it was the same thing day in and day out, day in and day out. There was no stimulus from having students around or being involved in an academic environment. I guess had there been a medical school, or a teaching program, I'd probably still be there today. I recognized the lack when I got into private practice in an office setting where I took care of patients all day long, both in the hospital and the office. But there were no residents around; there were no students. When I was working hard, Tony was home sleeping, and when I was sleeping, he was working hard, because it was just the two of us. So we didn't have much academic interchange. We talked about specific patients and helped each other; obviously, we got along fine that way. But there was no stimulus. Anyone in academics knows that the value of being around students is they ask you questions all the time and challenge what it is you do, and they challenge the status quo. I realized very soon that I was in the wrong place. Not the wrong locale — that wasn't it; but in the wrong professional environment, which, of course, proved to be the case. After I went back to New Jersey and taught for two years, and when the legislature decided on the school here, I came right back. I would have stayed in Las Vegas if the school had been there at the time.

When you decided it was wrong, did you look around? Did you do a job search?

No, as a matter of fact, that was pure serendipity. I was unhappy, and Celia, my wife, knew that. I got a phone call from another friend from medical school, who was working in the New Jersey College of Medicine in Newark. He called me up and said, "How's it going?"

"Oh, fine." You know, we communicated through the years on Christmas cards. "Oh, not so red-hot. Oh, it's all right, I guess."

He said, "Well, we're looking for a pediatrician to come here and run our residency program."

I had just been involved with resident education in the air force in San Antonio. So I said, "Well, I'll . . . yes, I think I'd like to consider that. I don't really want to go back to New Jersey." It contradicted our decision earlier to stay in the Southwest, but it was a matter of compromise. So Celia and I talked about it, and I went back. I was interviewed; I liked the people there; and I immediately recognized I would be teaching students and residents. I'd be in an academic environment, and I said, "OK, I'll take it." In the spring of '67 I went to the New Jersey College of Medicine, Saint Michael's Medical Center, as director of pediatrics.

We left Las Vegas with some personal disappointment. I mean, we hated to leave our friends, but then I really had in the back of my mind that, "Someday Nevada is going to grow. Ted Jacobs and the others were right; this is going to be a growing community. Someday there'll probably be a medical school. And if not, there'll be other medical schools." And there were at that time, just beginning; they were getting started in Albuquerque, New Mexico; Arizona. All of them were just starting medical schools in the early sixties to the early seventies. There were twenty-five or thirty new medical schools, maybe even more

— forty — developed all over the country. So I knew there would be more medical schools developing; the federal government was pushing the development of new medical schools; society was saying we needed more doctors. I knew that by going to an academic environment for a couple years, even if it was in the center of hell, that eventually there would opportunities elsewhere, probably in the Southwest again.

So we went back to New Jersey with that in mind, “I’ll get back into academics, and I’ll try to develop a little reputation and teach, and then when something evolves or develops in the West — whether it’s New Mexico, Arizona, southern California, who knows where — I’ll go back.” So, within two years, by ‘69 all of a sudden the Nevada legislature wanted to start a medical school, and they said they were going to put it on the campus in Reno. My prediction, or at least my internal clock, was right. I got on the phone and contacted some people who I knew both in Reno and Las Vegas, and took another big risk and came out here. Celia and I were very happy to return in Nevada, and it worked. Could have a bummer; I mean the school could have failed, I guess, and the whole thing could have closed. Then I would have looked for something else. But . . .

So you were keeping your eye on what was going on in the West?

Oh, absolutely, absolutely, oh, sure. One of my friends, Dr. Jim Gorman, who was a surgeon practicing in Las Vegas, was at Kennedy Airport on his way back to Madrid to visit. Since we were in New Jersey, he called, and, in the course of our conversation, he told me of the decision to start a medical school in Nevada.

I got on the phone, and I talked to several people who I knew. Was this true? Yes, it was true. I was looking at ads then for jobs on the West Coast, and noticed an ad in the New England Journal for the job as director of medical education at Washoe Medical Center in conjunction with the development of the school. I called the number they gave, I got on the plane, I came out, and I was interviewed.

I met Dr. Mack, the surgeon from Reno who was very involved in the development of the school and Washoe Medical, and Bob Barnett and Dave Roberts, and a number of physicians who were on that committee. Dr. Mack hired me for the job. I met George Smith and Fred Anderson — they were all talking about the medical school developing, and they wanted to have a director of medical education at Washoe Medical Center. That job would be to run all of the educational programs in the hospital, so that students from the medical school, which would be a two-year program at that time, could go to Washoe to learn how to do histories and physicals. That would also be where they’d get their clinical experience, along with the V.A. My other role was, of course, to conduct continuing education programs for the physicians, and essentially try to improve or upgrade, if you will, the academic educational environment at Washoe, so that it would be acceptable to the medical school and vice versa.

I was hired at Washoe Medical Center in July, and moved my family in August of ‘69. The school was due to open with its first students in August of ‘71. So there was a two-year lead time to get the curriculum developed, do all this development I just mentioned, get the physicians prepared, because the idea was to have practicing physicians participate in the teaching and supervision of the students.

Yes, there would be basic scientists in anatomy and physiology and biochemistry, but there would also be physician involvement. And there were very few full-time people. Dr. Smith started the school with just a handful; he had an anatomist and physiologist, and I was, I guess, the second or third person hired.

Then Dr. Smith asked me, with the permission and agreement of Dr. Mack and the people at Washoe, if I could do some committee work. He appointed me chairman of the curriculum committee to get the curriculum put on paper. Then he asked me if I would come to the school full-time and be his associate dean. I did that half-time for about a year, and then left Washoe Medical Center and joined the medical school full-time as the associate dean. I was doing that when the school opened in the fall of '71. As associate dean, I did what the associate deans do: see that the curriculum was developed, and see that the school was being run. And so that's how I did it.

How do you go about developing a curriculum? Do you look at other medical schools?

Yes, and a lot of that had been done by George Smith as a part of the plan to sell the medical school to the Board of Regents and to the university. How do other medical schools do it? What sort of innovations are going on in medicine right now? What's it going to cost? How much tax dollars? What are the tuitions going to be? Where will these students get transferred? A whole bunch of questions, which George had already addressed.

By the time I got here, my job was basically to get the four or five basic scientists, who had been hired, and four or five or six physicians from town together. God, I think we met every week for a couple of hours on a Wednesday afternoon, even in the evenings.

We would just sit down and say, "OK. Here're the two years. Here's what they've got to learn. This is what's required by the accrediting bodies. This is what will be expected on the national board examinations." There are a number of parameters you look at, and then you sit down and say, "OK. Monday morning they've got to learn the anatomy of the heart. And Tuesday morning they've got to learn the anatomy of the lungs, whatever." Put it on a piece of paper, and then assign the task to the various teachers. Basically at that point you wanted to be sure that the students at the end of two years could be transferred to a four-year school. When we first opened those first five or six years, they had to transfer. We had to be sure that they were of the same quality as students finishing two years at any other established school. We had to be sure they could pass the national boards, which they did. We had to be sure that they could walk onto a ward as a junior clerk at some other school, and be able to do a history and physical, and fit right in. All of that proved to be true. The end points were pretty well established for us. Here's what the accrediting body expects; here's what the national board exams will ask about; here's what the transfer schools will expect of your students.

Was the two-year setup fairly common at that point in time? Or was Nevada's program unusual?

It was fairly common, but it was the end of that era. There were many, many well-established medical schools that had been two-year schools for years, beginning back in the thirties and into the forties, and then converted into full four-year schools in the fifties and sixties. For example, Utah was a two-year school originally; so was the University of Washington. Dartmouth

Medical School was for years, thirty, forty years. They never graduated any doctors from Dartmouth; their students would always, after two years, go to Harvard or Boston or some other place. North and South Dakota had two-year schools for years, beginning before the war.

So there were a lot of two-year schools, particularly in the West. These were the underpopulated states prior to the war and up to the 1960s, where the states didn't have a lot of money; they didn't have large cities; they didn't have big hospitals. They got their students into medical school by developing a two-year school, providing the basic science academics on their college campuses — University of North Dakota, University of Washington, University of Utah, whatever — and then transferred them to the big cities.

In the sixties, however, that slowly began to fade away. By then Washington, Utah, and some of those were all four-year schools. North and South Dakota were converting. We were a two-year school soon to convert. Dartmouth was in the process of converting. I'm almost sure there are no two-year schools left in the country, although I think Indiana and the University of Washington still have programs where they'll have students spend a year at Notre Dame or at Purdue, or, in the case of Washington, they'll spend a year in Idaho or Montana. But a free-standing two-year school from which all the students must be transferred to a four-year school — those days are over. I think we were one of the last to have converted, which we did in 1978.

Was it started with the intent that it would develop into a four-year program?

I don't think so. I wasn't here when George Smith made his presentations to the legislature. What I was told, and what I believe

to be true, was at that the time it was presented to the legislature as a two-year school, and that in the sixties — '67, '68, '69 — was deemed to be sufficient. It was felt there would be enough places to transfer. Well, that projection, that prediction (predictions are often wrong), turned out not to be the case. Many of the schools that traditionally took two-year transfer students, from Nevada, North and South Dakota, other places, like Dartmouth, were closing down, and they said, "We have enough of our own students; we can't take any of yours. We're sorry, we can't do it any longer. We can't give you a twenty-year contract or a forty-year contract."

So you had a contract? The students just weren't on their own when they were done, trying to find a place to transfer to? Did the school facilitate the transfer?

Oh, yes, exactly. Dr. Owen Peck spent practically full-time running around the country finding the places. There was no specific contract with the school saying, "Yes, we'll take ten of your students." It was all on an individual case-by-case basis, but we had a full-time assistant dean who essentially did that. Starting in the fall of the second year, he'd go around to all the schools and say, "How many students can you take?"

"Well, we think we can take three, or maybe we can take four, or maybe we can take only one."

So he would say, "OK, well, you know, I've got a student who I think would fit your school." So it was very, very much an individual selling job of the school and the student with his or her record, to get them transferred. There was no "Just send us ten each year," none of that kind of a contract.

Then, of course, after the first three or four years of that, the message was coming through

loud and clear: “You better not depend upon us in the future, because we are expanding our own freshman class; we’re not going to have any more room for transfers in the third and fourth years. We’re filled to the gills.” So that was a big, strong motivation for going back to the legislature in ‘77 with a proposal to convert the school. And that was approved in the spring of ‘77.

In ‘71 the school opened. So they would have graduated their first class in ‘73. How many students?

We had five classes that we transferred of roughly forty students. So about 190 students were transferred. Then the school was approved for conversion in the spring of ‘77. Shortly thereafter, Dean Smith resigned in that summer, and I was appointed the dean in October of ‘77. I spent the next couple of years recruiting the chairman and getting the school converted. So the class that would have left in ‘78 stayed and became our first graduating M.D. class in ‘80. That was the end of the transfers.

There were a few in that first class who came to the school saying, “I came here expecting to be transferred, so I don’t want to stay.” Of that class of forty-eight, I think seven or eight transferred on their own, without our help, essentially. But there had been a track record of five classes before that.

Was the process for gearing up to a four-year school similar to what it was in establishing the two-year school? Was it simpler?

It was much more complex, more compressed, because we only had two years in which to do it in order to get the federal dollars, which were part of the incentive to get the conversion. The message from the

federal government was that, “We’re not going to support two-year schools any longer. You either become a four-year school — do it yourself — or get out of the business.” The message from many of the established schools was, “Don’t count on us to take your students any longer.” So there were several motivations. The negative motivation — we may not be able to get our kids transferred — and the positive motivation — that if we go to a four-year school we can be self-sufficient and won’t have to depend upon others, and we can get a fair amount of federal dollars that were available at the time.

But the crunch was to do that — was to get that done in a matter of two years. In the spring of ‘77, the legislature approved it, and we started our national search for chairman in the summer of ‘77. Dr. Smith resigned, and I was appointed the dean. I started interviewing people for the various clinical faculty and department jobs from Thanksgiving to Christmas of ‘77. By March of ‘78, less than a year from the time the legislature passed that law, I had hired six department chairmen, all of whom agreed to show up and start with the first class of students in August of ‘78. From the time the school was approved in June of ‘77, within one year, we had six clinical department chairmen here and a program ready to go at Washoe and the V.A. It was all here in Reno, with the exception of OB — we did OB in Vegas — but here, everything else. Those chairmen were here, and they were teaching that first class of juniors in the summer of ‘78.

How did the connection work between north and south?

Well, initially, there was very little connection, because the Liaison Committee for Medical Education, which is the body that

accredits all medical schools — if you don't have accreditation from that body, you're not a school, not in this country, and you don't get any dollars; you get nothing. That body came here twice during that year and said, "It looks like you can make it, but you're going to have to keep all of your students together here in Reno in one place, where you can keep an eye on them and have control and have all of your faculty focused." We had to work out a plan to provide the six required clinical experiences.

What are the six required clinical experiences?

Medicine, surgery, obstetrics, pediatrics, psychiatry, and family practice. Those are the six, more or less equally distributed, although they actually get more time in medicine and surgery. That makes up the third year. The fourth year, of course, is a lot of electives, where they'll get the subspecialties like ophthalmology and ear, nose and throat. We send them to rural communities, and they get experience in orthopedics and all sorts of experiences in subspecialties. But the basic six — medicine, surgery, pediatrics, OB, psychiatry, and family practice — all were to be done in Reno. All the chairmen came here; we hired them here; they went and recruited faculty. We were ready to go. We were ready to go on July first of '78, except we couldn't get OB.

What was the problem?

Well, we couldn't get much cooperation at that time from the obstetricians in town to have obstetrics taught here. Of course, there were no obstetrics at the V.A. Many of the Reno obstetricians were not interested, whereas there was a large group of obstetricians in Las Vegas who were interested in academics, who had already established a residency in

obstetrics a number of years before. They had an association with a hospital in San Francisco, and also with Tulane University. Southern Nevada Memorial Hospital, which is now the University Medical Center, had a residency affiliation in OB. So I went down. I knew many of them, many were my friends, and I said, "I have got to have a place where I can put third-year medical students to learn OB. Will you take them?" The answer was yes. So the students did all of their third and most of their fourth year here in Reno, except they had to go to Las Vegas for eight weeks to do obstetrics.

At that time, Mr. Claude Howard, who was one of the benefactors of this place, and who gave us a lot of money, owned lots of apartments down there. He provided apartments free for the students to go down there. I called the LCME, and I think I went back to Washington and talked to the secretary, and I said, "Look. We can do everything that we promised in Reno, except we can't get obstetrics here, at least not now. And here's the plan I have for Las Vegas in order to provide obstetrics."

Had you recruited a chair in OB?

No, we couldn't get a chair that would be acceptable to the people here. There were a lot of reasons; I don't know all of them, and some of them were never revealed to me. But I just couldn't get them to agree. I think the other part of it was almost all of the obstetrics done in Reno at the time was private. There were very few indigent patients. Whereas Southern Nevada Memorial Hospital was in a burgeoning, growing area, Las Vegas. There were a lot of indigent patients who were going to Southern Nevada for their obstetrics. They had no insurance, had no private doctors. They were cared for and treated and delivered

by residents from these two programs I just mentioned.

So there was an educational environment there and they said, “Yes, send the students to us.” I think we sent them six every eight weeks, something like that. And the LCME agreed to that. They said, “OK. We’ll see how it works.”

Well, it turned out, interestingly enough, but not surprisingly, that for a number of years in those first years — the obstetrics program in southern Nevada would be rated by the students as the best experience they had as third-year students. There was a lot of patient activity, and all the students got to deliver babies. There was a lot of supervision and a lot of positive faculty. Not that the other programs were poor, but they just liked it very much. So when the LCME came back the next year or two years later, they said, “OK, that’s acceptable.”

Then, of course, in ‘79 I resigned as the dean for reasons of health, and there was a year with an active dean, and then Dr. Daugherty showed up in ‘81. Slowly, in the last thirteen years, there’s been an increasing amount of activity in Las Vegas. But that’s no longer a concern. First of all, Vegas is growing; the LCME sees us as a maturing school, and that’s acceptable somehow. We have students, as you know, in Las Vegas doing surgery — doing everything. They do everything now in Las Vegas.

Do you have programs then for all of your six areas in both north and south? Do the students get to choose?

Good question. Right now, they must do OB still in Las Vegas; there’s no choice — they go to Vegas for OB. They go to Vegas for pediatrics now. They choose medicine, either place. Surgery, they must go to both cities — part surgery is down there, and part surgery

up here. Psychiatry, they get to choose. Family practice, they get to choose. So it’s a mixed bag, depending upon individual departments, resources and patients, and number of faculty. I think I’d be right by saying that of fifty students we now have in the third year, right today there’re probably thirty of them in Vegas and twenty of them in Reno, roughly. That’s more or less the proportion month after month.

The senior year is a different thing. Senior year, they can go out of state; they can go all over the country; they can go around the world. They go lots of places. They’re not required to stay in either Las Vegas or Reno, though most of them do, because they have homes, they have families, they have lots of reasons. I’m guessing again, but about half of the senior student body is probably in Vegas and Reno right now, right today. And the other half are probably spread all over California and Utah and all over the place.

How does that work? What are they doing in their senior year?

They’re doing electives, the elective subspecialties, and they have to get approval from our dean of education or dean of curriculum. So they might, for example, go to the University of Utah and take a month of neurosurgery, or another one might go to the University of Washington and take a month of radiology. Somebody else is in Albuquerque, New Mexico, at the University of New Mexico, taking a month in cancer therapy. Somebody else is over at UC Davis doing a month in emergency room. Then plenty of seniors are doing similar kinds of electives at the V.A. and Washoe in Reno and down in Las Vegas. But they tend to do them in the various subspecialties, which they haven’t gotten experience with in the junior

year. A lot of it's done out of state. And we have had a couple students who have gone and spent a month in central Africa or gone to Nepal or various places because they have a particular interest. A number of students have taken tropical medicine in Guatemala. But fundamentally, most of them are doing their senior year in Reno, Vegas, and in the surrounding western states.

Do you foresee in the future possibly having the course work up here, and eventually all the students doing the clinical down in Las Vegas because of the population?

That could very well happen, sure. I'm not predicting, you know, and I'm not speaking for the school at all, but, sure, I don't see any reason why that couldn't happen. Frankly, the first two years could be taught anywhere. I guess you could teach in Tonopah or wherever you had a building and some basic scientists and some cadavers and some microscopes. We, of course, have our students do a lot of clinical work in the first two years, so they do have to go to the V.A. and Washoe. I guess that's basically an issue of where do you have buildings, and where do you have faculty? But the clinical programs obviously have to have patients, so you've got to go where the patients are. I think that, speaking for the school, our dean feels that we ought to the best we can use all the resources of the state, and have our students do clinical work throughout the state. But you're right in that the underlying question you're asking is, will more and more of the clinical programs be in Las Vegas? I think the answer will be yes, because that's where more and more of the patients will be.

On the other hand, who's going to predict the future of the economy and the population and all that sort of stuff? There were many people who did not predict that Nevada

would have 1.5 million people living in it this year, you know. Most people didn't think we'd reach a million till the turn of the century. So we're way ahead of the population projection. I remember, when I made the presentations to the legislature in 1977, many critics of the school and many people who didn't want to see it developed said, "Well, we're too small; we can't afford it. There's not enough people." Well, that was proven to be wrong. We can afford it, and there's plenty of patients, and, as a matter of fact, more than we need, frankly, right now.

In 1979 you resigned as dean for health reasons. Can you talk about that?

Oh, sure. I had been very tired; I was exhausted, and I was depressed. I thought it was my job, and a lot of other people thought it was the job, too. I'd been working day and night for two years — well, three years, I guess. By coincidence I had hired Dr. Mazzaferri, as chairman of the Department of Medicine, who was an endocrinologist by training. Ernie Mazzaferri. He's now chairman of the Department of Medicine of Ohio State in Columbus. He started the Department of Medicine, did a wonderful job, and was well respected by everybody.

I wasn't feeling well, so I went to see him as a physician. I had another physician, and I don't know, I guess I wanted a second opinion, or maybe down deep maybe I wasn't confident that the physician I was seeing was aware of how sick I was. After a couple of visits, he said, "Oh, I think the evidence I have from the laboratory and other tests suggests that this isn't just stress from work. You're sick. You've got a disease."

I said, "Which disease is that?"

He said, "I think you have hyperparathyroidism — overactive parathyroid

glands.” He did all the appropriate tests, and, in fact, he was right. So he sent me down to UC San Francisco, where I saw a world-famous parathyroid surgeon, Dr. Orlo Clark, who was on the faculty there. He agreed, and he operated on me and took out my parathyroids, which under the microscope were proven to be overactive.

It’s a complicated disease, but basically it affects your kidney function; it affects your blood pressure, which was high; it causes high calcium, so that affects your alertness. So a lot of the depression and a lot of the fatigue and the exhaustion and inability to concentrate and focus were all related to this disease. Ultimately, it was the cause of my renal failure, because that was in ‘79. By ‘87 my kidneys failed, and I went and had a kidney transplant at the same place, at UC San Francisco. And I knew that was going to happen over a period of time.

At any rate, I came back, and a week went by, two weeks went by, and a month went by, and I still didn’t have a lot of energy. I was still recovering, and the school was at its critical point. It was the fall of ‘79, and we had our second third-year class, and we had our first senior class due to graduate the following spring of ‘80. I went to see the president and talked to some friends and talked to Dr. Mazzaferri, and said, “You know, I don’t have the energy to do this, the job that needs to be done, in fairness to the school.” So I resigned in October of ‘79.

Joe Crowley met with some of the faculty and appointed Ernie Mazzaferri as the acting dean, and he took over as the acting dean for a year, year and a half, until Bob Daugherty was then recruited to be the permanent dean. Ernie subsequently went back to Ohio State. I resigned then and took about six months’ sick leave till the next spring, and then came back and joined the Department of Pediatrics,

which had a residency and students. I taught in the Department of Pediatrics and worked in the Special Children’s Clinic for the next, I don’t know, ten years.

The hyperparathyroidism caused renal damage?

Over time, yes, and I probably had some renal disease at the time, but it took awhile. I had the parathyroid problem in ‘79; then I had some more surgery done in 1985, and at that time my kidneys were failing. I had up to a year before I would be on dialysis, so in the spring of 1987 I wrote a letter to my five children and to my six brothers and sisters. I told them about it and said that I would be on dialysis probably that summer or would need a transplant. Which I did with some hesitation because I certainly didn’t want to coerce or pressure or cajole or . . . I don’t even know what the right word would be, any of my brothers or sisters. It turned out all of my kids and my brothers and sisters wrote back and said they would be happy to give me one of their kidneys, because you only need one, and you’ve got two. It turned out that older sister, who was nine years older, had the best immunologic match. She was just retiring from the New York school system as a school teacher and said, “Sure, I’d be happy, have one of mine.” So she came out to San Francisco, and they put her through all the tests, and she was found to be quite healthy. She was sixty-three at the time, and her kidney was functioning well, and she said, “Fine, take it.” So, I never actually went on dialysis, though I was close to it because my kidneys were down to functioning at about 5 percent of normal or something like that.

So, we went into surgery in June of ‘87. She did fine and I did fine, and it’s worked well since. I watch my diet, and I’m on anti-rejection medication because we’re not

twins; we don't have a perfect match. Now theoretically, since we have a good match, there may be the possibility that those drugs could be stopped, but I'm not going to become a guinea pig to find that out. I'm doing fine; I'm not going to rock the boat. And my sister's doing fine. She's living very well on one kidney; that's all you need. And she's active in retirement.

She'd be what . . . about 70?

She's 70 years old. Actually the year after she — this is interesting — she joined the Peace Corps and went to Cameroon, West Africa, to teach English and social studies in a teachers's college in the "bush." When she returned, she volunteered at the state prison in New Jersey, teaching prisoners, helping them learn how to read and write the English language. She also works at a Senior Citizen Center, teaching writing to seniors who want to practice writing. She's a very active woman, and she's done very well for seven or eight years now with just the one kidney. So I am very grateful to her and to the rest of my family, who are all very supportive. So that's worked fine.

While you were here and involved as dean, essentially you were out of the academics. It was more of an administrative job?

Yes, for those two years, although I'd always insisted, and I think I carried generally through, on one afternoon a week where I went to the clinic and was with students. I just checked out of my office, and that was it; I'm not here for the whatever it was — Thursday afternoon, I'm not here. I thought it was important, so I always taught. I always gave a lecture or went to a clinic one afternoon a week. I wasn't carrying on a practice; I wasn't

seeing patients other than the patients that were seen in the clinic.

Do you find it easier to keep up on what's happening in your field because of the teaching and not being in private practice, or possibly more difficult?

From my perspective — I can't speak for others — I think it's much easier. First of all, let's face it, when you're in practice, your first duty is to your patients, always, whether that's nights or weekends or whatever. And next to your patients are your family and your own personal life. But when you're in academics, you don't have a patient responsibility — or only peripherally. Your real responsibility is to your students and to the institution. Nobody is calling you at night or weekends to come out and see them; you don't have to get up out of a meeting because your beeper calls, and you've got to go see the patient who's gotten worse in the hospital. So the demands upon you in an academic environment are quite different than the demands in private practice.

But if you're still doing some of your specialty, you're teaching in it. Being in an academic environment, first of all, gives you more time to read and stay abreast of what's going on, I think; but also, you get the daily or weekly challenge of questions by students that you may not get in your private practice. It's those questions that force you to go home and say, "Oh, my goodness, I don't know what the answer is; I better start looking that up." I think that the stimulus to do research, and the stimulus to stay abreast of recent developments is integral to an academic environment. I wouldn't want to say that people in private practice aren't keeping up; I hope they are. Certainly the physicians I go to are, but it's tough.

There are many physicians who want to stay involved with students, for that reason, because it is a stimulus. Lots of young physicians — actually alumni of this school, who I talk to all the time, including two of my own children who are physicians — really enjoy having students. They can't spend a lot of time at it, because their practice would suffer, but having a student in their office two hours on a Thursday afternoon or occasionally helping out in a clinic or something — it gives them a break from what they're doing, but it also gives them some reality testing of what the younger generation is thinking about. It's too bad we don't have a system that provides an opportunity for all physicians to stay active, if only for a few hours a week, in some teaching/student environment. It's particularly hard to do when a community doesn't have enough physicians. In a community that has too many physicians, it's hard to do because there's such competition. If you're not available and around for your patients, somebody else will be. It's an interesting paradox.

Patients, you know, some of them can be quite fickle; they want to be seen now! Not in an hour or two; they want to be seen now. If you're not available, "Well, I'll call somebody else!" That's why emergency rooms are filled with people who ought to be seeing their general physician in an office setting. But they procrastinate. They wait till they're sick, and then they go to an emergency room, and want to be seen immediately.

After talking to a number of physicians on this project — and there are number of them nearing the end of their professional life — one common theme is that they found being a physician very difficult on their personal life.

Oh, yes.

I've had several say, "If I didn't have a strong wife, the family would have fallen apart."

No question.

And others have commented that they simply don't want to work the long hours and give up a family life.

Yes.

Do you see a change occurring?

Yes, I do, definitely. I think the younger generation of physicians have taken a different attitude. I don't mean this as a sexist remark, but the quote that has always been ascribed to Sir William Osler was that "Medicine is a jealous mistress." There's a lot of truth to that. When you are a physician with patients who are depending upon you, first of all there're enormous rewards — lots of rewards — but it is also very demanding of your time and your energy. Your duty, when you're dealing with a patient, is to put your full focus and attention on that patient and his or her problems, including to the exclusion of the secretary or your wife or your kid's soccer game, or the lawyer or the IRS, or whoever. The moment I'm seeing you as my patient, you are the focus of my attention. If you have a busy practice, and you get overextended financially, or that's one of the few places where you get joy in life, where most of your gratification comes from that, it's very easy to be seduced, if you will, into spending more and more and more time with your patient, longer and longer hours. Then finding that the rest of your life is falling apart, either because it isn't worth keeping and you want it to fall apart, or it's falling apart because you're not paying attention to it, or you're not getting satisfaction in other parts of your life — I'm

parroting what a lot of doctors tell me. They have demands on their time and demands for more money, or whatever. It's very comforting to say, "Well, at least when I'm with my patients, I'm appreciated; I'm doing what I was trained to do; I feel good about it; I get a lot of rewards." And the ambivalence of saying, "But by the same token, God, I'm being overworked; I'm not appreciated at home; I'm not appreciated here; I'm not appreciated there. Everybody's demanding things." This is the sort of paradoxical kind of attitude you hear expressed.

Imbedded in all of that, is the potential for drug and alcohol abuse, high in our profession, and divorce, depression, suicide, a lot of problems of unhappiness. With, I guess, in the general sense, unhappiness being fairly prevalent in the medical profession. Many of the, what I call younger generation physicians, let's say early to late twenties, early thirties to forty-five, that group, who've gotten out of school in the last fifteen years, let's say post-Vietnam, have been attuned to that. Many of them have established different ways of practicing, less solo practice, less partnership practice, much more going into larger groups. They have more regular time, being on-call and being off-call. They're not "devoting all of their time and energy just to their practice," but looking at other places in their lives that need to be nurtured and fostered and supported. I think, I think that doesn't mean that the next generation won't have similar problems or different ones, but I think younger generations of physicians, let's say under the age of forty-five, are more attuned to the problems. They are trying to establish practice styles as well as life styles that are more compatible than maybe the physicians of my generation, or even older, who are over sixty. It's mostly men, because when I was in medical school, there were very

few women, so I think women have had an effect on the attitude change in medicine, no question in my mind, the last thirty years.

Why do you think that's so?

Because I think that women, many of them, want to have family lives. I think they have a different attitude about work, work, work. Maybe that's being too stereotypical, but I just think that now with virtually half, almost half, of the medical school classes female that we see a lot of different changing attitudes.

The percentage of women in medical school is not quite 50 percent nationally. I think it's running around 40 percent, and in our school it's around 40 percent. Which isn't surprising — half the people in the country are women. But that was not the case when I went to medical school in the early fifties. I don't think we had a woman in our class. There might have been a woman in the class ahead of us, and there might have been a handful, two or three women in 200 medical students over four years. Now, with 40 percent of our student body female, with 190-some odd medical students, we must have least eighty-five or ninety that are women. Many of them married, many of them with two, three, and four children. We've had babies delivered, you know, all freshman, sophomore, junior, seniors having babies.

So, many women and men are going into groups. Now, part of that isn't only driven by the physicians and their desires, it's also driven by the economy. Managed care and health maintenance organizations and all these are gathering physicians into large groups where you're not expected to be on-call all the time. "We just want our fifty or sixty hours out of you, and you're on-call ten hours today." A lot of young physicians go into emergency medicine for that reason, they'll

tell you. Many of them go into anesthesia for that reason.

They work their ten or twelve hours shift and they're off. When they walk out the door, they have no duty, no obligation, nobody is going to call them. The next doctor comes on and picks up the pieces. Then they go home, and know that when they're off on Thursday afternoon or off for the whole weekend, they can plan with the wife and kids to go skiing, or can plan to go to San Francisco. Or they can go to a soccer game. Or if single or don't have families, they can date or get on a plane and fly to LA, or do what they damn please.

I never heard that kind of discussion when I was in medical school. I never heard that kind of discussion when I was a resident. Not that I can recall. It was, "Well, you'll probably go into a practice, and maybe you'll have a partner or two, and when duty calls, you're available." So I think you're right about what you expressed in your question about what many physicians my age and older who say they could become, and have become. There are many examples in our community and Vegas, of the career becoming destructive or of physicians allowing it to be destructive of relationships. Younger physicians, I don't think, are willing to accept that as a price of being "a successful physician." Many people, many patients, don't understand that; all they understand is when I used to see Dr. Jones or Dr. Smith or Dr. Scully, he was my doctor, he was attentive to me, or she was attentive to me, and he was wonderful. They have no idea what goes on in the person's life.

We see the results of that in the Board of Medical Examiners, as you know from talking to other members. Many of the complaints we get, looking at the negative side, is "He doesn't listen, he doesn't pay attention to me, he doesn't call me back and answer my calls, he doesn't seem to be up-front with me,

he doesn't tell me the truth, he seems to be distant, or I think I smelled alcohol on his breath, or he's late for his appointment, or I'm always kept waiting." I mean, it's all sorts of complaints, and they often revolve around what I would generalize as "communication," interpersonal communication and a sense of caring or a sense of not caring, as perceived by the patient: "he doesn't really care." So a lot of the negative comments we hear about physicians, particularly at the Board in the form of complaints, are not that he's a terrible doctor and cut off the wrong leg; it's often that "he doesn't talk to me; he doesn't seem to listen," that sort of thing.

So . . . that's a roundabout way of answering your question, but I do think you're right. I can't speak for other professions, but if you allow it, it's understandable how a physician can become consumed by his practice or her patients, to the detriment of other parts of his or her development.

Do you think this changed attitude that you perceive in this new generation has the potential for affecting the quality of medical care? Either pro or negative?

I think frankly it ought to be on the positive side. My rationale would be that physicians who take care of themselves do a better job taking care of their patients. On the contrary, those physicians who don't take care of themselves, those physicians who don't look after their mental health, who become depressed or get involved in drugs or alcohol or have marital problems or whatever, I don't think have the emotional energy to pay attention to their patients when they are with their patients. So on the balance I would see that this is more positive than negative. There's a lot of argument about sleep deprivation, fatigue, inability of

physicians to concentrate, more mistakes made after the tenth, eleventh, or twelfth hour. There has certainly been concern about that expressed in the way in which many residents in training spend long hours, and I think physicians can get caught up in the same thing. So I think on the negative side, physicians who have not taken care of their health, who are subject to sleep deprivation, stress, and along with those things, run the risk of being less effective physicians. I think there's a lot that can be said for physicians who can live a more regular life, can get a decent night's sleep, have time off, pay attention to the rest of their development, become more well-rounded, if you will, personalities, in the long run, being better physicians. Then when they are with their patients, whether that's fifty or sixty or seventy hours a week, put their full attention to their patients, knowing that when they're off, they can then spend time on the other parts of their life. So I think it's very important, and I would say on balance; it would be more positive than negative.

Now there are a lot of physicians probably my age and older, who would say, "Oh, well, that's just liberal poppycock. That's emotional, psycho-social, psychological gobbledygook. The real good doctors are the ones who are totally devoted and dedicated, who work their fingers to the bone and are always available to their patients." I'm not so sure that the facts would bear that up.

It's interesting that you mention sleep deprivation, because a lot of hospitals in the last ten years or so have put staff, nursing staff, on twelve-hour shifts.

Yes, that's tough. If you're taking care of real sick patients, I imagine it is. I haven't talked to many nurses about how they feel about that. I guess you could argue that if you

get a couple of twelve-hour shifts a week, you can handle it, but I'm talking about people who are around for eighteen, twenty hours, thirty-six hours. I don't think that's right. I don't think that's good patient care. I know there are people who argue, "Well, you've got to be around, spend the time, and be with your patients," but I think it just means to me that we haven't spent enough creative energy in trying to develop some other way in which the physician in training can be scheduled. The patients get better care when physicians in training get more breaks and free time.

The other thing I think people should realize is I don't think it's fair to talk about the way I was trained forty years ago, because it was a totally different environment. I think the stress and the pressure that young physicians in training are under now is quite different than thirty and forty years ago. Because thirty and forty years ago, we didn't have ICUs; we didn't ventilate people on ventilators — there were none; we didn't do cardio-pulmonary resuscitation — it hadn't been invented; we didn't shock hearts back. We didn't do any of that stuff. We didn't transplant anybody. Sure there was major surgery that kept you all night long, but in those days — I mean I'm just talking about the fifties — much of the modern technology which is so a part of care of the sick patient now, with tubes in every orifice and all this mechanics and fancy electronics, very little of that was around in the fifties, or even early sixties. So that many of the physicians trained in those days who say, "Well, you know, I was on for twenty-four or thirty-six hours," when you really find out what was going on, they were frequently asleep on the couch for several hours. When they did get up, they weren't expected to handle the same amount of technology or deal with the same kinds of critical events. I don't think we can compare.

I don't think it's fair for older physicians, my age, to say, "Well, I did it when I was young; you can do it, too," sort of like a fraternity initiation nonsense. It's crazy. It's a whole different world; if the stresses and the demands upon the young physicians are different, then we have to accommodate by changing the way in which they're trained. That doesn't make them worse physicians. Makes them probably better.

Are they working fewer hours now as residents?

Yes, they are. I think our departments are doing a good job, and, of course, nationally. Of course, that event that took place in Cornell a few years ago brought it all to the public's attention. A young lady died in Cornell Medical Center in New York hospital, and there was a lot of criticism that the residents who had been on for thirty-six hours missed the ball and dropped the ball. And she died as a result of mismanagement. I don't know if that was ever proven, but it focused the national attention on sleep deprivation and the need for physicians in training to have more time to sleep and read and take care of their personal life, as we were just talking about, than simply hanging around the hospital.

But is there a contradiction here, to a certain extent? Because you've mentioned the technology, how much more complex it has gotten, so we're backing off on hours and time devoted to it in a time when we have more to learn. Is there a problem there?

Yes, that's one of the arguments. With physicians in training, I think we have to look very carefully at their training and how much time they have. I'm not talking about the physician in practice. If it means we just have

to have more physicians and more physician's assistants and better-trained nurses, and more of them, well, fine, so be it for the care of patients. But I don't think it follows that we have to force the student in training to spend longer hours because they can go home after eight or ten hours and come back the next day. Someone picks up the pieces in the middle, and they come back and find out what's going on the next morning. I've heard that argument, "Oh, you've got to be around here for thirty-six hours to know what's going on."

Do we need a two-year internship, a three-year residency?

Well, all the residencies are now. The minimum training for any resident now is three years. The specialties I mentioned earlier: medicine is three, pediatrics is three, OB is four, psychiatry is four, general surgery is four and most five, family practice is three. Of course, you know in this state, and other states are following, the Board of Medical Examiners, through our law, requires a minimum of three years graduate training after medical school. So that's four years of medical school and three years of graduate training in a residency, before you can get a license to practice.

They've done away with an internship?

Yes, we don't even call it that anymore. There are physicians in this state and many states who are in practice, who had a one-year internship back in — oh, prior to the 1970s. Very few since 1975. I did a study for the Board; then we went to the legislature in '85. We said we want our law to say three years for everybody, minimum, three years after medical school. The study I did then revealed that close to 99 percent of all graduating

medical students went into and finished at least three years of training. And that goes back twenty years now, to 1974 or 1975, so that is the norm. There are a few who after one year will attempt to go into practice, but more and more states are expecting at least two years, and, of course, Nevada expects three.

So that part of the answer to the question is: you don't have to learn it all in one year. The internship year that we all had years ago — and that was sufficient for most physicians to go into practice — well, there was very little to learn in that one year, basically.

But those were rotating internships.

Yes, you went through everything.

And you do that now in your clinical and medical schools so that you can make a decision about where you want to work?

Yes. As I suggested earlier, in the third year, they rotate through the six major specialties. Then in the senior year, they're expected to take various subspecialties. By the time they're ready to start their graduate training, usually that decision's made in March of their senior year; they have made a decision to go into one of the specialties. Now, once they get into one of those specialties, no, they don't rotate through the others. They're into surgery, or they're into psychiatry. Sure, they'll do some pediatric psychiatry, or they'll do some pediatric surgery, but they're basically now into that specialty. Family medicine has got some OB, some pediatrics, of course, some general medicine, some minor surgery. So young physicians who want to do a little bit of everything tend to go into family medicine. People who want to become super-specialized and knowledgeable in one field may go into neuro-surgery or ophthalmology where they,

after four, five, six, or seven years, know everything there virtually is to know about that one organ, and that's what they deal with.

Choices have a lot to do with the physician's personality and desire and interest and the kinds of people they want to deal with and work with. So much of what goes on in medical school is a process of professionalization, trying to decide who am I going to be when I grow up, and what sort of area in medicine am I going to be happiest?

When I was in medical school, medical students stood around and watched. They sat in lecture halls and were lectured to, and they stood around and watched. They didn't do very much. I don't think I delivered a baby in medical school. That's what you did when you got in your internship, although there were exceptions to all this.

Now we have students in second, third, or third and fourth year, who are doing a lot. They are actively involved in the practice of medicine. So it's not only sitting and listening to lectures; there's very little of that. They're not just standing around watching; they're involved. They're scrubbing in and holding . . . well, that's not true. When I was in medical school, I went to surgery and held retractors. It helped me decide not to become a surgeon. But still there wasn't the same degree of involvement.

When I got out of medical school in 1958 — that's thirty-six years ago — most of my classmates, including myself, felt very inadequate, and we were looking forward to a rotating internship where finally, we would do some things, you know; we would do medicine. If you wanted to go beyond that, you would go into a specialty, which I did in pediatrics. Now, I think that much of that has sort of been pushed down, or brought down, or displaced, I guess, into the third and fourth year of medical school. Our hope is that our

students leaving in the senior year will have had a little bit more of a clinical experience, beginning in their second year, so that by the time that they get to be seniors they've got a little bit better view of what they want to do. And yet, we see all the time seniors coming up to graduation saying, "Geez, I'm not sure I know what I'm doing." Certainly we know from the literature, and my own personal experience, that about 15 percent of graduates of medical schools nationwide change their specialty training within five years after leaving medical school. So there's a 15 percent, if you will, dissatisfaction rate or change rate. They went into surgery, and said, "I'm in the wrong place, I want to go into something else."

So they would have to go back to school? Or back to a residency?

They would just change residencies. Sure. We have two young students, former students of ours, alumni, who have come back to do medicine in family practice, who left here three years ago and went into other specialties. They called me a year or two ago and were unhappy — they made the wrong decision, which is all right. Sometimes you don't know that you have made the wrong decision until you've done it. I've always kidded students — and I'm just giving you an example of my own life, you know — what am I going to do when I grow up? There's nothing wrong with changing, unless it's anxiety producing.

We've had physicians who have done general medicine, and gone back and decided after ten years that they wanted to be a radiologist or an ophthalmologist. Generally, I think that the studies that have been done on that show that physicians who've been in practice tend to go back into subspecialty

training. They've done the general practice, the general medicine, now they want to be a subspecialist of some kind. Others, just do all of that before they go into practice.

The other thing you have to remember, in the last thirty years, certainly in my professional lifetime, is the development of so many specialties. In the fifties, you had about five or six choices; in the sixties, you got ten choices; in the seventies, you probably had fifteen choices; in the eighties and nineties, you got forty choices — twenty major specialties and twenty-four or twenty-five subspecialties. Now you can be a gastroenterologist or a cardiologist or an allergist or an immunologist or infect . . . I mean, there are so many "ologists" around. You can be any one of those and have a successful living and enjoy what you are doing.

Now that pendulum seems to be swinging back now to more generalists, better-trained generalists. Not just one-year internship, but three-year family medicine or three-year internal medicine or three years of pediatrics will become, if you will, the central funnel point for people going into managed care. You'll see a generalist first; you won't just call up your cardiologist and say, "I'm having a pain in my foot," and you won't call up your gastroenterologist because you've got a headache; you'll go to your generalist. Then he or she will refer you on as necessary, so there will be a shift.

We're seeing that nationally the number of residency positions in general medicine, which is around 30 percent or so of residency positions now in this country, is shifting, the hope being by the turn of the century that half of them will be in general medicine. The 65 percent or 70 percent that are subspecialty residencies now will be compressed down so that in the future — I don't know, ten, fifteen

years out — you'll see more generalist, fewer subspecialists. But there are still going to be people getting transplants, and still people are going to have their cataracts taken out, and there is still going to be lot's of specialty medicine. The expectation is, however, that the generalists will do a better job of taking care of a lot of those things, and there will be less need for specialists.

Could you tell me little bit about your interest in and work in medical ethics?

I resigned as the dean in 1979, as you recall, and then I worked at the Special Children's Clinic for a couple of years. In 1982, I applied for and got a sabbatical leave; I had been with the school about twelve years. My proposal was to study in a formal way, medical ethics, with the view to coming back to the medical school and introducing courses and discussions on medical ethics into the medical student curriculum. At that time this was being recommended all over the country. There were a lots of issues at that time, actually; they were still talking about Karen Quinlan, the famous case in New Jersey. There were other similar cases around the country, with people on life support and the resulting issues of whether or not to remove people from life support and under what circumstances. There was also a lot of public furor about the ethics of abortion, issues about the use of fetal tissues for research. And then, of course, we were becoming more and more aware of the elderly and Alzheimer's disease, so a lot of the ethical issues were on the horizon that were being studied around the country in formal ways. Other than philosophers, there were actually very few physicians who had any formal background in philosophy or medical ethics, and there was little or no teaching in any medical school on the subject including the University of Nevada, School of Medicine.

So I got a leave, went to New York with my wife, and we lived with her mother in the suburbs of New York. I spent a year at the Hasting Center, which is world famous, started in 1969 by Dan Callahan, essentially to study ethical issues. They got started actually with ethics of research and the use of human subjects in research. At any rate, I was there for a full year as a visiting scholar. I studied in a formal way, I went to classes, I sat in seminars, I did a lot of independent reading, and also visited a number of medical schools in the East which were beginning to teach ethics. So I put together a curriculum with the idea that when I came back here, I would introduce it. I was there from the fall of '82 to the fall of '83. When I returned, I presented, through the curriculum committee, a proposal, and I think the next year we introduced the formal classes in medical ethics for medical students in the second year. We also began to have conferences with third- and fourth-year students and residents.

At the same time, with my wife, who is a professional writer and journalist, I started looking at the lay literature. We were trying to find what was available to the average person to read about these ethical issues. It was one thing to have literature for the philosopher and the physician and the attorney, but we didn't see anything that was really written in simple phrase and without a lot of jargon, written for the average citizen. So she and I got the idea to write a book on these medical ethical issues, the ones I was just talking about, for the general public. We put together a proposal, I guess it was in '85, sent it to our agent, because my wife has already published another book on health writing, and our agent got it sold to Simon and Schuster. We wrote the book with that contract, and spent almost a year and half at it. My wife was writing almost full time, and I would work at home a couple of days a week.

We got that ready for publication, sent in the final documents in the spring of 1987 and, lo and behold, at that time I was headed for the hospital to get a kidney transplant, so Simon and Schuster held up the publication for almost six months. Actually I remember, at UC San Francisco, when I was recuperating from the kidney transplant, Celia and I sat in my room, and we actually did the galley proofs and made all the editorial changes and sent it in. Then the editor, in a polite way, said, "We want to be sure that Tom survives, and he is going to be able to go on book tours," because there is nothing worse than having a book published and then have the author die [laughter] and not be able to sell her own book. The author is the best salesman of her own book. So it was kind of funny, but it was very nice the way it was said over the phone, so Celia said, "Well, he is doing very well," and our physician talked to him and said, "Yes, we anticipate that he is going to do well."

Six months later I was healthy and back to work. Simon and Schuster then published the book, and it was released in March of '88. Celia and I went all over the country, and I was on hundreds of radio shows by phone, television shows, and other kinds of book signings, et cetera, for that book. So the sabbatical not only led to my knowing and learning something about ethics and being able to teach that at the school, since I always have done well at teaching, but also it led to the publication of the first book that I ever authored. My wife has authored other things. It's now in the paperback, and I have done a lot of public speaking about it as well. Now that I have been a patient, I look at a lot of these issues — not from the medical standpoint or physician's viewpoint, though I understand that viewpoint — but I tend to look at a lot of these issues from the patient's viewpoint. That is how the book is written,

so that's what happened. The last ten years, I have been teaching ethics at the medical school and talking about it in public. I will probably continue to do that even if I semi-retire or start reducing my workload over the next few years.

One thing that seems to have happened recently with medical ethics, is government involvement . . .

Yes!

. . . because of federal funding with the fetal tissue research you mentioned.

Yes, yes.

Who's responsibility is that sort of thing?

Well, it is a joint responsibility, I guess. We cannot forget the holocaust; we cannot forget Nuremberg; we can't forget that people in the past have been used as objects without their permission. This has been the history, unfortunately, so we have to be very careful that the person involved, whether he or she is the patient or the potential mother of a patient in the case of a pregnant woman, understands fully what the ethical issues are. That they understand what they are agreeing to, and what not agreeing to; and I think that there needs to be some oversight. To me these are issues that are not reserved just to the profession; they are not reserved just to medicine or science. These issues affect the entire society's view of their values, especially in a pluralistic society like the United States, where we are multi-cultural, we have lots of different religious backgrounds or no religious background. We come to these from a variety of viewpoints.

It's essential, I think, that government be involved in the political process, by which there is built-in protection, so that people's rights are not abused, and they are treated fairly. Of course, once the government, through tax dollars, supports some of this research, they have even more interest in seeing that the certain rules are followed. The President's Commission for the Study of Ethics — it has a longer name but that's briefly what it was — was founded in 1981 or 1982, I guess, and went until about '84 or '85. There was about a three-year period where some of the best ethicists and physicians and people in the country came together in meetings all over the country and really established guidelines. They now have a nine-volume set of guidelines for all sorts of ethical issues, whether it's research on fetal tissues, up to and including withholding life support to someone who is in the vegetative state, or institutionalizing the mentally retarded, or . . . you know, anything you can think about. So I think to say, "Whose responsibility?" I say it's the person involved; it's the physician or scientist involved with him or her and the institutions, hospitals and other institutions in society. And the government, particularly, when funding is involved. Whatever is being done must be open, above board. It also has to be accepted, at least by the majority of society, and I think that's the only way that we can guard against the repetition of the past history of people being used as objects for somebody else's benefit.

Legislation is often involved in this. An example is the Oregon law on assisted suicide. The law is involved, the court is involved, and the physician is involved with medical ethics. How does the physician resolve these issues of medical ethics, which can change with the political climate so quickly?

Well, hopefully the ethics wouldn't change with the political climate. His ability or her ability as a physician to act on their feelings, however, might be quite limited. That is, a physician may in conscience believe that patients who are terminal with severe suffering have the right to be left alone, and ask to be assisted with their suicide or their dying. That doesn't mean that the physician, even if there were a law, has to participate. This will always be an issue of conscientious objection. For example, in states which by law have lethal injection for capital punishment, physicians have the absolute right to say, "I don't participate in that", just as the physician traditionally can say, "I don't participate in abortion."

By the same token, a physician may, in conscience, believe that a law is restricting and inhibiting his ability to provide the best medical care for patients. We saw that in some of the cases of Karen Quinlan and Nancy Cruzan and others, where the laws in those states were not permitting the physician to withhold the feedings. They then went to courts, the Supreme Court in the case of Nancy Cruzan, but they have also gone to the legislature, gotten the laws changed or had the courts make the decisions through the political process, saying that this was ethically and legally acceptable to let someone die. There are both sides of the coin. There are things that physicians feel are in patients' best interest, but the laws limit him or her. There are others where the laws allow certain things that he or she is unwilling to do in conscience. So it's a tension, a natural tension, and a good tension. Frankly, I think these issues should be difficult to resolve; they should not be simple to resolve. If they are so simple that we can put a few formulas in a computer and punch a button, then I think we will have failed as a society of human beings. That will be

terrible. What we need is a society in which these issues are talked about openly, they are struggled with, there is a lot of tension built-in, that these decisions are not come to in a very quick and cavalier manner. Where there is a lot of struggle and lots of people are involved in the discussion. I think we have seen that, for example, in the resolution of the Nancy Cruzan case by the Supreme Court a couple of years ago. We have also seen and, let's face it, we are still in dealing with ethical issues surrounding abortion and the use of fetal tissues for research. There are not easy answers, but I would argue that they shouldn't be easy, they should be a struggle, that the entire society gets involved with it. It shouldn't be a few elitists who make these decisions and justify them on grounds that are not acceptable to the society.

Talleyrand said something about treason being a matter of the calendar. That what is treasonous one day, is patriotic the next.

Yes, that's right. Or today's orthodoxy is tomorrow's heresy, or vice versa.

It seems that these types of issues are something the Board has to deal with. What is legal one day, ethical or unethical may change with the legislative session.

Absolutely, it may change also with what goes on in science and research. Let's face it, I think you could argue that any physician who practiced medicine in 1994-95, the way they would have cared for the same illness in 1945, would be guilty of malpractice today. That is simply because the standards have changed, the knowledge base has changed, what's available has changed. A physician who does not adequately use antibiotics, for example, in the treatment of the infection would be

held liable for negligence. Whereas before they were available in 1930s, he or she had no other choice. So there is no question that what constitutes malpractice, or on the other side of the coin, what constitutes competent medical practice, is continually changing based upon the science of the time. The general medical principles don't tend to change, but their application changes. If you can transplant a heart, a liver or lung, then you raise all sort of questions about who ought to get a scarce resource and how should that decision be made. When you didn't have the technology that allowed the transplanting of heart, liver or lung, then there were no ethical issues.

Most of these issues were not even discussed when I was in medical school from 1954 to 1958 simply because there was very little we could do to patients to prolong their lives, so we didn't even get in such discussions. Now that we have the technology, that raises all the issues. So the advances in science and advance in technology do not generally answer the ethical issues; they raise more ethical issues as they go along simply because they raise questions that were never asked previously.

Since it is these types of medical and ethical issues that can be a part of the Board of Medical Examiner's responsibility, let's talk about your time with the Board. You were first appointed to the Board in 1977. How did your appointment come about?

Well, I was the associate dean here at the medical school. It was in the summer of '77, and the legislature had just approved the conversion of the medical school from a two-year to a four-year school. I had done a lot of that discussion at the legislature with Dr. Smith, who was the dean; and I, of course had met Governor Mike O'Callaghan on a

number of occasions, and we've talked about the school conversion. I think it was in June. The legislative session was over, Governor O'Callaghan called George Smith one day, and I was in George's office.

He said to George, "There is a place available on the Board of Medical Examiners, and I want someone from the medical school on the medical board. The medical school ought to have someone who knows academics involved in setting standards and all that, and I want you to serve."

George said, "I can't, Mike; we are going to be involved with converting the school, and I am going to be very busy. Why don't I put Tom Scully on the phone. He is sitting right here; maybe he would like to serve."

So Mike O'Callaghan said, "Put him on." I got on and he said, "Scully, you willing to serve?"

I said, "Yes. For how long?"

He said, "It's a four-year appointment. OK, you are appointed. I will get someone to call on the phone and talk to you about it." The next day he called Ken Maclean, who was the secretary of the Board at that time; Dick Grundy, from Carson City, was the president. I don't think we yet had a public member; I think we were just five physicians. I think public members came that year, the next fall, yes.

Ken Maclean called and said, "I just talked to the governor and he said you are going to be taking . . . " I don't know who's place it was, so I said, "Yes."

I went to the first meeting, I think in early September, and I just learned by seat of pants. In those days we did not have an open meeting law. I'm sure we must have had an agenda which was published, but it was pretty informal in that sense. Physicians who the Board were concerned about would be called in, and we would talk to them. There were

some formal complaints filed, as I recall that first year, and the exam process was pretty much an oral exam. We would sit there and interview doctors as a group or individually, and decide, but it was done fairly. Those early couple of years were fairly, I would say, "loose," is one word to use. The other is fairly informal, that is another word to use. There was a fair amount of decision making, which some might have thought arbitrary. Anyway, that's how it was done.

I just joined the other four physicians, and I was the fifth physician. There was Dick Grundy and Ted Jacobs and Ken Maclean and myself. I am trying to remember who was the fifth . . . Oh, the fifth physician, I think, was Norm Christensen . . . though maybe Norm took over when Grundy was off. There must have been another physician who escapes me at the moment. Anyway, five physician members, and then Harvey Kay and Ida Crockett were the first two public members. So we went from five physicians to seven with the addition of the two public members.

I was reappointed four years later by Bob List, and at the end of that four-year term, I resigned and was off for three years. I was reappointed in '88 by Dick Bryan, and then I was reappointed by Governor Miller in '92, and that term is over in '96. The law that was put in '85 limits anybody to two four-year terms, so I am finished in '96, and I support that law. There needs to be a changing of the guards; there needs to be new blood. They need to involve a lot more people. I've been appointed by four governors to serve sixteen years over a nineteen-year period. That's how it happened.

When you were licensed here, were you licensed by reciprocity?

I got my license in New York and in Pennsylvania and in Texas through the

National Board of Medical Examiners. I got out of the air force, and at that time you had to have a basic science certificate. The school I went to in New York state in those days did not have one. So I actually came out here in February of 1966, while still in the air force, and I actually took a basic science exam down in the Agriculture building on the UNR campus. It was a two-day exam, and there were fifteen or twenty or thirty of us there. It was very basic science, basic chemistry and physics and stuff, which I hadn't studied in number of years. I passed that, and it was interesting. You had to be serious about getting a license, because I think the exam was on Monday and Tuesday, and then they graded it overnight. Dean Fletcher, I think, was the head of that board and he was a chemist, biochemist, who later worked in the medical school. He and some others graded those exams by hand, and then I think we met with the Board of Medical Examiners down in their building on Baker Lane. That was Thursday of that week, so you have to sit around a hotel for the whole week practically. Then I went in, and there were five of them in a room. I remember Ken Maclean, I remember Les Moren, and I don't remember who the other three were. There were five of them sitting there, and, hell, there were only a few of us getting our license in February. As I said, I had to spend a week — it wasn't done through the mail; I can tell you that. We sat there, and they asked me a whole bunch of questions in my specialty.

I evidently satisfied them, and I was told I would get my license. I got it in the mail, I don't know, in March, and got out of the air force in late June, and came to Las Vegas and went into the practice. That was in the summer of '66.

So that was your experience with the Board until you became a member in '77. In that eleven-year period, did the Board even impinge upon your consciousness?

No. I knew nothing about it. No, never, because I wasn't involved in any way. They did their own exam; they didn't depend on anybody else to help them there. I was never disciplined, or never got any complaint against me, so I didn't think of that.

I always knew that Ken Maclean was head of the Board; everyone just sort of looked at Ken as the Board, if you spoke with the Board in those days. Most of the physicians were in Reno anyway; Vegas was just beginning to grow, so it was mostly whatever Ken Maclean said. I don't recall he or the Board impacting me or my life or the medical school at that time. I am sure Dr. Smith, as the dean, had interaction with them, but it was pretty much — and statistics bear this out — it was pretty much giving licenses to people who met the minimum standards and came for an interview. You met the Board, and they talked to you about medicine, and they asked you questions, so you could not do it by mail. You had to be serious, I guess, and that probably limited the numbers licensed to a certain extent, because many other states, even then and now, you send your stuff in, and six months later you get something in the mail and they give a license. They never see you or talk to you; they simply review your credentials. That wasn't the way it was here, and I don't recall any impact at all.

Frankly, when the governor, Mike O'Callaghan called George, the very moment on the phone when he said, "I appoint you," I hadn't the slightest idea what was involved. When Ken Maclean called me the next day, I said, "What is involved?"

He said, "We meet three times a year, usually a day in Reno and occasionally go to Vegas. We meet physicians and license them, and occasionally we have a," in Ken's words, "bad actor or bad apple we have to discipline."

I said, "OK, fine, count me in." So, as I just said, it was a fairly informal process. It was basically the appointment of public members and the Open Meeting Law and all the issues around due process and hearings and all that, that formalized it more in the early eighties.

There were some issues, and some of these predate your time on the Board, that I would like to talk to you about simply because, as a physician, to a certain extent you were affected by them. One issue is acupuncture, and that was in '73. Were you aware of what was going on with it at that time?

No, although I remember a lot of stuff in the newspaper about Laetrile and Gerovital. Acupuncture? Yes, I remember that. I thought that was even later, '75 or even '77.

The first time it came up was '73.

I don't know when it was passed. They put it as Chinese medicine, and I recall there were several acupuncturists who actually went down to Carson City. I remember the stories of legislators who had sore backs or sore necks or twisted something or other, who would get acupuncture either in the legislature building or in the hotel nearby. I remember that was a political process, in which the advocates of acupuncture got that in and subsequently homeopathy and naturopathy and a number of those. I was on the Board when the homeopathic board was established, but a lot of the acupuncture, Gerovital, Laetrile, some of those issues, the legislature specifically exempted them from

discipline. Before I was on the Board, I was vaguely aware of them.

I did have one involvement with the Board before I was appointed, and that was in the early seventies, when Dr. Smith was asked to put together a committee to study the physician's assistants' programs around the country. Mike O'Callaghan wanted to start physician's assistants, which was at that time touted as a way of providing health care for under-served rural communities, and Matt Bach was appointed the head of the committee. He is now dead, a physiologist, and I was on that and a few others, so I remember going down to the legislature a couple of times maybe in the '73 and '75 sessions, talking about physician's assistants. That would have been maybe the only other thing I had anything to do with the Board at that time.

How do you feel about physician's assistants?

Oh, I'm very positive about them. We have now about eighty physician's assistants licensed by the Board. I have forgotten when they started. I think they started maybe '75 or '77. I've forgotten; I have to look it up.

I think it might have been '73.

It might have been, yes; it's in the book someplace, but let me just open the thing to physician's assistants. It looks like the first physician's assistant went in '73 — boy, you got a good memory — that's what it says here: '73. So I was on that committee, and in '73 I was the chairman of the curriculum committee at the medical school. The question was whether the medical school would train physician's assistants, and the answer was, our hands were full just training medical students. There were good programs in Utah and in Washington,

state of Washington, and around the country, so we didn't get involved in training them or educating them.

Back to the original question; we have eighty of them now licensed. They have an excellent record. I don't know if we have ever publicly disciplined any of them. They work under the direct supervision of the physician so that we hold the practicing, licensed physician accountable for the behavior of his or her physician's assistant. They have been an excellent resource.

As was predicted at the time, most of them do not practice in rural communities. Most of them practice in Las Vegas and Reno. I don't have those figures in front of me, but there are some who do practice in rural communities, and now the medical school is involved in trying to train more physician's assistants who will commit themselves to go to a rural community to settle right now.

So is the medical school now training physician's assistants?

No, they have an agreement through their office of rural health to take people from rural Nevada and send them to the University of Washington in the Seattle, where they get their training. They bring them back to Nevada for some of their clinical work and then place them in rural communities, mostly the communities from which they came and where, presumably, they have attachments in family. They then practice in those communities. There are several that Caroline Ford has done that for. So we don't even train them, but we facilitate their getting into the program in Washington and bringing them back to Nevada.

Physician's assistants, as far as we can tell from the Board's viewpoint, have been a real asset to the state, and the physicians who

hire them generally swear by them. They are carefully regulated, and they are under the jurisdiction of the Board, and I think they have been excellent.

But not necessarily in the rural communities where you had envisioned them?

Not to the numbers, though I can't give you the figures. There are ten of them in Elko, Ely, Lovelock, Carson, and in Winnemucca, and there are several in Eureka and in Yerington. Out of the eighty, I think that probably forty-some-odd are in Vegas, twenty-some-odd are in Reno and Carson, and the other ten to fifteen in rural communities. But the original idea that they would be essentially practicing rural medicine was sort of naive in the first place. When you think about it, with the population in rural Nevada, if you provided ten P.A.'s and twenty doctors tomorrow, it would probably take care of all the needs of most rural communities.

P.A.'s have also reflected what's gone on in medicine: many of them have become sub-specialized. There are P.A.'s who do just heart work, and there are P.A.'s who do orthopedic work, and there are P.A.'s who do family medicine. Now, of course, along with it there are also nurse practitioners over whom our Board has no jurisdictions, but they are also a wonderful resource. I have worked with a number of nurse practitioners, but they are governed by the nursing board.

How do nurse practitioners differ from P.A.'s?

Well, they have a nursing background to begin with. They have more independent practices because they go on and get a couple of years of training beyond the nursing school. They work in collaboration with the physicians, but they don't have to work

directly under a physician everyday the way a P.A. does. They probably have a broader scientific background because many P.A.'s are originally military corpsman who had very limited professional or educational background, but very good technical skills, and there is a difference in that. The nurse practitioners have more leeway under the law in writing prescriptions and in making independent judgements as opposed to P.A.'s.

One issue — again, this is before you were there on the Board, but it affects you as a physician and affects you now as a member of the Board — is Continuing Medical Education. It was broached several times, and 1975 when it was started.

It was usually shot down, as I recall, by a variety of people because the arguments were that education didn't guarantee behavior. There was this feeling that somehow, by some legislators and others, that if we require the continuing education of physicians, they would be better physicians. I think the evidence is if you require Continuing Medical Education, you might very well improve the physician's knowledge base, and help him or her keep up with what's going on in medicine, but it does not guarantee that the physician will practice better medicine. Sitting in a classroom and learning about the new treatment for a disease does not mean that you are then going to go back to your office or hospital and introduce that, nor does it mean that you will be a better physician. So there was a certain amount of "if you throw enough mud, some of it will stick" and therefore will make better doctors. I think there was also the feeling that it makes some sense to at least require a physician to review every year what it is that they do.

Can I argue that required Continuing Medical Education has made better physicians in Nevada? I don't know that I have any way of proving that. I still support it, and what ended up was the legislature simply said you will do it by regulation, and so the Board then had public hearings with physicians on both sides of the coin. Eventually we adopted the regulations, which required forty hours.

These aren't the credit hours the way university does credit hours, are they?

Yes, they are. They are forty category-one credit hours. The standards are put out by the AMA; the AMA has a council on Continuing Medical Education. These are credit hours, where you go sign in, you take a course, and you often take an exam. You can't get those forty hours by sitting at home and reading a journal, or you can't get those credits by saying, "I took care of five patients with a specific disease." It has to be credit hours of formal education.

There are some tapes put out by specialty boards that you can listen to, and you can only get the credit if you take their exam and send the stuff in. There has to be some proof at the other end, usually Chicago where most of these specialty boards have their offices, that you in fact have taken an exam and demonstrated that you have listened to the tapes. Just ordering them and getting them in the mail and letting them sit on your shelves doesn't satisfy the requirements. Many of the CME programs around the country and in hospitals are getting much more structured about proof that you actually were there — that you didn't sign in at nine o'clock and played golf all day, came back in at five o'clock and signed out. I guess you could do that, but in many places they have you signing in mornings, afternoons, and evenings. I am

sure there are a lot of different ways people can fudge the system if they want to. The fundamental issue of requiring physicians to attend courses I still believe is a good one, although, as I said, I don't know that anyone can prove that it makes better doctors.

They don't have to take any kind of exam to show that they have actually absorbed this information?

Some do, but that's all individual, and most places do not give exams. That's been a big issue around the country, not in Nevada, but some states have actually discussed a requirement that once you are licensed, you have to be re-licensed after so many years. New York had some legislation, which didn't pass, proposing that physicians would actually have to take an exam every ten years and get re-licensed. As it now stands, in all states, including Nevada, if you get a license and it's not removed or disciplined, and you haven't had any action against your license, you can continue to practice with that license for twenty, thirty, forty years. There're a lot of people who feel that the public would be better served if there was some periodic re-licensure or re-certification. That's not being done, although there are a number of specialty boards that have both mandatory or voluntary re-certification; their physician will go and take that board's specialty exam because they want to be re-certified. And that's catching on; more and more people are doing that. But re-licensure has not yet been mandated by any legislature in the country that I am aware of as of today.

There are re-licensure exams available for physicians, for example, who have been disciplined or have been out ill for a couple of years, or who have been in a drug or alcohol treatment program, or who have been

disciplined and lost their license, or wish to move to another state. Many states, including Nevada, now require that if you have not taken a licensure exam in the previous ten years, then you've got to take one before you can move across the border. So it is sort of working its way into the system for those physicians who have been out of practice for a while, and the presumption is that they are no longer competent, or at least the competency can be questioned and they need to be re-tested — that's one group. The other is people who move around the country, leave one practice and go into another state, and have to demonstrate to the new state that they are competent. But if you stay within your own state and have your license and you have no actions against it, there is no requirement at the moment for re-licensure.

What do you think about that?

I personally am in favor of re-certification; I think it's a good idea. I think that eventually we will probably get re-licensure, but it won't be the state boards doing all the detailed stuff that they now do. It will probably be something like — this is a guess — it will probably be something like: you are a specialist in whatever your specialty is, you go every ten years and prove to that specialty board that you are competent in their specialty, you can hang their certificate on the wall, you can put your advertisement in the yellow pages, you can call yourself a board-certified X-Y-Z, and that certificate then goes to your licensing board, and your licensing board renews your license for the next ten years. I think something like that is going to happen, but I don't see much appetite on the part of the licensing board putting in the very expensive and necessary mechanisms to re-license its four or five or six or seven

thousand doctors every ten years. It would be a monumental task. I think it would also be an enormous expense and time consuming to try and identify the handful or maybe even the fifty or sixty doctors who are losing it or not keeping up or not being competent.

But you have to also look at the disciplinary statistics; many of the disciplinary actions against physicians don't have a lot to do with his or her competence to take good care of a patient. It's that they get over-worked, or they are affected by drugs or alcohol, or they get too busy and they cut corners and they get sloppy; they don't get consultations, or they get greedy. There're a lot of other ways in which physicians get into trouble, and yet, if you sit them down to take an exam, they can answer all of your questions. It's back to the issue of CME — there's no proof that if you can answer a question on an exam, or sit in a class and get one-hundred on an exam, that you will necessarily translate that into better care of your patients. If you are still too busy, and you're sloppy, and you're not applying what you know, then that's bad medicine. But, getting a re-license exam passed or passing a board certification exam isn't going to deal with that issue.

You're a good test taker, and it means that you have a good knowledge base in your specialty. It doesn't mean that you are going to apply it properly, so there're two issues there. There're those who have argued that re-certification, re-licensure, or even CME gives the public a false sense of security, that this person who has got all these credentials on the wall is a good doctor. And he or she may not be. Yet, there would be other physicians who haven't sat down and done all of the academic work, who practice very good medicine because they know their limits, they refer appropriately, they get second opinions, they spend time with their patients, they do a lot of other things that make a good physician.

And so we're really also talking about what the public perception of what a good physician is, as opposed to the profession's perception of who their good colleagues are and who are not. They are often quite different.

You know, patients want to be cared for, they want to be listened to, they want to be treated gently and kindly, and they want someone to be concerned, but sometimes that may not be the behavior of some of the brightest, technically most proficient physicians in a community. So there's a lot yet we don't know how to measure; there're still a lot of things that make good physicians or don't make good physicians or interfere with a physician becoming incompetent, or interfere with his maintaining competence, that we don't have good ways of measuring.

So I'm ambivalent, but I guess if I had to come down on a side, I would come down on the side of re-certification by specialty. Where there's any basis for believing that a physician is not maintaining his or her proficiency that the Board has the right to order a additional CME or competency exam, and, in fact, we do that. We've had a number of examples — I can't discuss the particulars because they are confidential — but a number of instances in which complaints have come in against physicians. If the investigative committee of the Board believes that after hearing evidence that there's a question about this man's competency or woman's, then he or she is ordered to go and take a one-month course and pass exams to demonstrate their competence. The Board has that authority right now, but it's on a case-by-case basis, based upon complaints and representations of somebody, maybe a hospital staff or others, that this physician is incompetent. That's different than just saying across the board 100 percent of physicians must prove their competency every X number of years.

Beyond medical school and clinical programs, residencies, there really is no measurement of actual competency once you get into the profession.

That's correct, unless you take a board certification exam by one of the twenty-four or twenty-five boards, and most physicians do that.

Is that a clinical exam, as well as written?

Oh, it's both. It's usually several days of written and several days of clinical. They are very extensive exams because that specialty, on the base of that, is saying you are up to our level. Remember, licensing sets minimum standards of competency for public protection; specialty boards set optimal levels of proficiency, a much higher standard, and don't certify everybody who sits for their exams. They set a higher standard for that physician to say, "I am board certified by the American Board of Surgery or Obstetrics or Pediatrics," so they set much higher standard in that sense. Whereas, state licensure exams generally set minimum standards to assure the public that this physician has minimum competency. But, yes, as I suggested earlier, there're a number of those specialty boards that require physicians to re-take their specialty exams every seven to ten years. I've forgotten specifics; in family medicine I think it's maybe seven, orthopedics it might be ten. In order for a physician to represent himself publicly as specialized, then he has to take those kinds of exams. But, you're right, many physicians can finish their three years of residency, get a license in a state, and as long as their record is clean and they don't get disciplined, and they keep their hospital privileges, and they meet their forty hours of CME every two years, and they pay their fee

every two years, and there's no complaints against them, then, yes, they can continue that process under the present law for an entire lifetime. Many physicians do and practice quite well.

In 1977 when you came on the Board is when they brought on public members. Can you give me your insights into that?

Well, I think I have been very supportive of the public members. I guess I was as skeptical as any other physician at the time, but my experience has told me that they have been an enormous asset to the Board. Virtually every one of them took their job seriously that I can recall, and I've worked with seven or eight. When there was illness involved, a few didn't attend every meeting, but no one has a perfect record. They have been a very vocal and appropriate voice of the public. They have, on many occasions, brought up members of the Board short by asking questions that we just assumed as physicians; they didn't and they needed answers. They have sat in as voting members on hearings. They haven't voted on giving licenses because they are not competent to judge the medical competency of a physician — that is, how much knowledge he has. But they certainly, like any public juror, can sit and listen to a complaint against a physician, listen to the evidence, and make an independent judgement about whether the physician is guilty as charged. I can't think of a down side of any of them. I think they've always been conscientious, hard-working, did their homework, and I think, maybe most importantly, would often raise questions that required the Board to stop and think, "What is it we're doing and how does our action, in whatever action we're taking, improve the quality of medicine? How is that going to affect the public?" Then, of course, they've

been very tough and often tougher than physicians in listening to, in public hearings, complaints against physicians and finding some of the actions of my colleagues appalling and voting for stringent disciplinary action against physicians. All that's in the public record.

I think, although there was skepticism originally, that the members of the Board who have worked with the public members would find that they have been very hard-working and very positive; that's certainly my feeling.

You said that there was skepticism at first. How were the public members integrated into the Board?

Well, Mike O'Callaghan appointed Harvey Kay and Ida Crockett that first year. I have no idea how he appointed them or why, and none of my business; it's his right to appoint whomever he wants. The first six months it was very difficult for them, because the physicians, including Ken Maclean, who was running the Board at the time, didn't know what to expect from them or what their role was. They didn't really know what their role was and we sort of fumbled around, I guess is the best way to put it, for a while. This was happening all over the country, with public members being put on boards all over the country with open meeting laws being developed, which affected boards.

The Federation of State Medical Boards and the AMA started putting on conferences talking about the role of the public member in a licensing board or in a professional board. It was not only medicine, but dentistry, probably engineering, and everybody else was putting on public members. And so our public members . . . I remember I went to one that Harvey Kay and Ida Crockett went to in Chicago, attended, and they began to

come back and say, "Well, I've attended these meetings, and public members ought to be doing this or doing that." Over the course of a year or so, I think they then became just a part of the Board. They were thought no different, and they voted on things, and had their say. In many instances they were helpful in future legislation.

Do you have a public member on the investigative committee?

Oh, yes, and we always have since the time it was formed as a part of the '85 law. See, prior to the 1985, it was the secretary only who investigated all complaints, so it was Ken Maclean's job until he retired. It became my job for a couple of years, and that's one of the reasons I found this job to be impossible for one person to maintain objectivity, in my view. Ken — I won't comment on whether or how he did or did not do it. I can say the two years, from '83 to '85, I was doing it, I said, "This is an impossible task for one person; no one person has the breadth of knowledge." Maybe Ken did; I didn't. There's all sort of opportunities for conflict of interest, and it's just too stressful. So, I was the one that got the Board in '84 to say, "We have got to go the legislature and change this law; this is impossible."

The summer of '84 we hired some attorneys; we got some consultants in from other boards; we actually had workshops; we brought in people from Washington and Oregon and other states who had much more progressive laws, in my view. We sat down and spent several weekends and a number of weeknights, and actually, with Ted Jacob's direction, because I think he was president at the time, we wrote the law as we wanted it. It included the three years of residency for licensure, and it included increasing

the Board's size. It created an investigative committee of three people, one of whom must be a public member, so there wasn't just the secretary, and then began to separate the investigative committee from the rest of the Board, so there could be a committee to investigate and a committee to adjudicate. We wrote all of that into the law, took it to the legislature (I've forgotten what committee it was), and almost exactly as we asked, it passed right on through the legislature, with some modification. That was really, to me, in my lifetime in Nevada, the most important change that took place in the law. There were minor changes before, physician's assistants and subsequently some minor changes, but 1985 was the major re-write of the law which essentially now is the basis for our investigative committee with public members. The public members are involved in all aspects of the committee. The last couple of years a public member was our vice-president, and on a few occasions when Dr. Jacobs was not available, she chaired the meeting, did a wonderful job. So public members have been involved now in all aspects of the Board.

Were there any issues that you considered in changing the 1985 law, that you didn't implement, can you remember?

That's a good question. What actually happened is, the previous year I was appointed to a committee at the Federation of State Medical Boards, which met in Dallas. I went to three or four meetings there, and the committee was developing, from a nationwide perspective with lots of people, a model medical practice act. A model act which would take care of all of the issues that appeared to be going on nationwide, everything: public members, open meeting laws, disciplinary action, et cetera. I was on

that committee, and the committee wrote a marvelous model, I thought. I brought that model back and in the summer of '84, as I just mentioned, and into the fall of '84, we used that to be a model for Nevada. We got our own attorney, Mr. Lessly, and we hired a couple of consultants from other states, as I just mentioned, and we put them all together. We took that law and wrote our own law for Nevada, as we saw it, and took that to the legislature.

Now, were there things that we wanted that didn't go through? You know, I can't — I could get out my minutes and my testimony to check. I think it went through more or less as we wanted it, with no substantive changes. We asked for authorization to charge more money for fees, because we wanted to have our own attorneys, we wanted to have our own investigators; we did not want to have to be dependent upon the attorney general's office. We did not want to have to be a part of some government agency where they had to approve everything; we wanted to maintain our autonomy, which we still have been able to do. That meant that we had to have our own budget; and I might just say parenthetically, we have never gotten one nickel of state tax, general fund dollars into our Board's budget. Every single dollar that we spend has come from the physicians' fees, and a small amount from the physician's assistant fee. But basically, the physicians' fees for getting licensed and maintaining their license has totally funded the Board, so we have been able to hire our own attorneys. Yes, we have a good relationship with the attorney general's office, but we have our own investigators, our own secretaries, our own people who do all our license investigation. We still live by the state rules on travel, and we live by the state rules on salaries and all that, but we're basically independent. That, I think, has been

important to the functioning of the Board, as far as I can see.

In the middle to late seventies, Nevada had to deal with the issue of foreign medical school graduates and off-shore medical schools.

Right. Absolutely. Well, there are two issues. First, of all, foreign medical graduates have been licensed in Nevada for a long time, and we have some excellent physicians who are foreign trained. The problem, from our perspective and my personal perspective, is there's no accreditation of the some 600 medical schools around the world to any degree that matches the accreditation of the 125 medical schools in this country. And Canada. So that the accreditation of the Canadian and the American medical schools is very strict, very rigid, and follows lots of rules and regulations. Schools have a lot of obligations before they get accredited. If you don't get an accredited medical school, your graduates, even though they may have an M.D. degree, can't get a license anyplace. Well, the 600 or so schools around the world vary from outstanding, excellent schools to fly-by-night, mediocre schools that hand out diplomas and are run out of a phone booth — literally. I mean some of the schools in the Caribbean that were investigated by the government: there was no faculty; there was no laboratory; there was nothing. Students went down and sat on the beach and read journals and read books and took exams, and were given all sorts of credentials which didn't mean much.

So we were then struggling, as we did with the law in '85, to try to somehow equate a foreign medical graduate, who has an excellent education in Bombay or in Tehran or in Beirut or in London or Paris, or in South Africa or in New Zealand — good schools

that have been established for a long period of time, that have excellent programs — how are they going to equate the products of those schools with some that were set up essentially as a mail-order house, almost?

All the states struggled with this, California, particularly, and New York, which had large numbers. It was very, very hard to do. There were attempts for a while to actually set up an international accrediting body through ECFMG, the Educational Council for Foreign Medical Graduates; that never went anywhere. The Federation of State Medical Boards tried to work on it for a while, had a committee that would go to a lot of schools and try to inspect them. It became very, very difficult. That was one of the arguments, one of the strongest arguments, when our Board went to our legislature (and you'll see it in my testimony), arguing for three years of graduate medical education for everyone, no matter where they went to medical school. At least, we would be able to say that everyone licensed in Nevada had three years of graduate education after the M.D. degree in a Canadian or an American graduate program. At least those were standardized, or fairly standardized. And we could assure the public that regardless of where the person got his or her M.D. degree, they at least had good graduate training and ought to be competent and not a danger. That was the strongest argument.

Now, the other thing at that time, in '85, we had a law in Nevada, which was passed back in the seventies, which required three years of graduate training for foreign graduates, but only one year for Americans. So we also argued, and our attorneys looked into it, that requirement was inherently discriminatory. That is, we were expecting more graduate training of foreign graduates than we were of Americans. That probably was OK for those foreign graduates who came from

questionable or mediocre schools, but that was certainly unfair to a lot of well-qualified foreign graduates from very good schools. So we then said, "Let's kill both those birds, if you will, with one stone. Ask the legislature to say three years will be the standard." Of course, I presented to the legislature the statistics that better than 95 percent of graduates in America get three years minimum anyway. So three years was the standard now. This was 1985. No longer were we back in the forties and fifties and sixties, where a one-year internship that I had might have been the standard (although I went on and had more residency training), but that was no longer the standard. They agreed with that, so starting in '85, the foreign graduate and the American graduate, wherever they went to school, had to at least have the three years.

In addition, we required that all of them come to Nevada and pass an oral examination that we gave with the help of fifty or sixty doctors around the state, trying to also reassure ourselves that the knowledge and training of these physicians was adequate. Even at that, there were graduates of some Caribbean and off-shore schools that just couldn't meet those standards. They couldn't even get into a residency, and some of them couldn't pass the national board examinations, or at that time it was the FLEX examination for foreign graduates.

Is that Foreign Licensing Examinations, the FLEX?

Yes and no. FLEX is the Federation's Licensing Examination. In fact, the Federation's Licensing Examination was developed for states to use for their own purposes, but also for the foreign graduate who was not eligible to take the national boards. Some states like Texas require it of

their own medical school graduates. That, of course, has all now gone by the wayside with the introduction of United States Medical Licensing Exam (USMLE), which is now being given worldwide to all graduates of all medical schools. So even some of the concerns that we had then about how are we going to equate the education and training of foreign graduates has been taken care of because of our state's advocacy for it and the Federation's advocacy of a uniform license exam that all graduates of all 800 medical schools in the world take. They all have to take the same exams on the same days and answer the same questions.

Now, the statistics show that the American graduates do better at this point, but at least that gave the opportunity for foreign graduates, no matter where they were in medical school, to compete on a fair, even turf with American graduates, number one. If they could pass the exams, then they could come to this country and get a residency. They'd then have to take three years of residency like any American graduate would take, and demonstrate to those residency directors in whatever specialty they were in that they were competent. We felt that kind of uniform examination and uniform training after medical school took care of the concern that the education in medical schools throughout the country and the world was quite variable. So that to me has handled the problem.

But there was a period of four or five years when it became very difficult to judge the credentials on paper of the physicians who got their M.D. degrees, particularly from some of the off-shore schools. Of course, some of those off-shore schools have just been shut down. Even the countries involved have closed them, and many of their graduates were unable to get into residencies in the United States or Canada. So now that a lot

of that has been taken care of, most of the foreign graduates who are competent, who get a decent education, can pass the USMLE and go through three years of residency training, whether they're foreign or American, and satisfy as I pointed out earlier, the minimum standard required to practice safely in this country. But it was a problem.

So you're testing them on paper; you're testing their knowledge. But by testing them before they get into the residency program, then you're doing your clinical testing.

That's correct. That's exactly right. The USMLE right now has three parts, very much modeled after the FLEX exams. The FLEX exam, which was essentially for foreign graduates, and the national board, which was for U.S. and Canadian graduates, were sort of melded together by committees over the last four or five years (I've been on a number of those committees) — to make a uniform exam worldwide.

There're three parts; each part is two days long, so that what essentially it is saying is that a physician or a medical student sometime in his second and third year takes two days of exams — written — four or five hundred questions. The end of their fourth year, before graduating, they take another two days of exams, four or five hundred questions. Then sometime in their first or second year of graduate training, they take another two-day exam, four or five hundred questions. If they pass those six days — roughly, what, fifteen hundred questions across the breadth of medicine — they've got their M.D. degree from some faculty of some school.

Then they've spent three years in their graduate training program under daily supervision, actually taking care of patients, and the Board gets a letter from that person

that they've done the three years. Then we feel quite comfortable that they've certainly met the minimum standards, and that they're comparable to the other fifteen thousand or so applicants for license in this country — that they're comparable and basically qualified. Then, of course, as you well know, many people go on for a fifth, sixth, seventh year of training and fellowship, and many of them get board certification in subspecialty boards and have more degrees than a thermometer. Basically we feel that sort of system which has evolved since '85, both here and nationwide, can assure the public of minimum competence.

When was USMLE actually implemented?

Oh, last year. I think they started it in '92. They had some practice sessions, I guess, in '91. It basically started in '92, and I think it's fully implemented this year. I think the last national board and FLEX exams were given last year. So now USMLE is the only standard. And it makes sense. It makes it a lot easier for everybody, here and in other countries, as well. If I wanted to go and practice in England or Scotland or wherever, I could then, or say my son could, demonstrate that he took the exact same exams on the exact same day as everybody else, and here's his grade. He passed.

These are objective questions — multiple choice?

Yes, yes, they're all multiple choice, and they're being computer scored, of course, yes. By the turn of the century these exams won't be given by boards of medical examiners or by medical schools. The student in question will go to one of twenty or thirty testing sites all over the world — Tokyo, Bombay, Cairo, London, Paris, and New York, San Francisco,

Chicago — fifteen or twenty. They will make an appointment, and they will go in, and they'll take whatever exam they're eligible for in that center, on their computer, and essentially be told as they walk out the door whether they passed or not.

The computer system will have so many questions in each category that, say, I go in, and of those fifteen hundred questions that I mentioned, for the sake of discussion, a hundred of them might deal with pediatrics. I'd take those hundred questions along with the other fourteen hundred, and pass them or flunk them. The next day a buddy of mine'll come in; he'll take a hundred questions in pediatrics. There'll be a different set of a hundred, but they will be joined in their degree of difficulty, so that his score of eighty on those hundred is the same as my score of eighty, although we were asked questions which were massaged by the computer. That's what a computer can do. Because a computer might have five thousand questions in pediatrics, of which I only saw a hundred. Five of them might be on immunization, and five of them might be on growth and development, and five of them might be on heart, and five of them might be on liver, and five might be on something else. The next physician the next day, sitting at the same computer, gets a random selection of five on the heart and five on the liver and five — but they're not the exact same questions I had. There's no way I could have told him what the questions are. So they're working on this now experimentally with the hope then that the fifteen or twenty thousand physicians worldwide who are trying to get licenses in this country won't have to all take them on April the fifteenth, or June the fourth. They can take them all year long, whenever it's convenient. All they need to do is demonstrate they've passed the exam. The people who know this kind of stuff say

when they build a big enough pool of twenty or thirty or forty thousand questions, get a database, they can massage this stuff. They can prove that my score of eighty is comparable to your score of eighty, and I took my exam last Thursday, and you took your exam yesterday. But the questions were of sufficient degree and covered the same subject that we both passed or failed the same exam. Of course, now everybody sits down and takes the exact same question every day. So that means all these people have to be gathered into rooms all over the country. It gets very complicated, but the national board does a beautiful job with it.

So it's the national board that's responsible?

Yes, they're responsible; they have a big contract with medical schools all over the country and all over the world, and with all the state boards. Right now every state board in the country — that's all they accept. Obviously, with people who passed these other exams two and three and four years ago, those are still valid. But for those graduating as of last year, from here on out, no matter where you come from, you will pass the same set of exams as anybody else. There was a lot of criticism by lobbying groups for the foreign medical graduates a few years ago. Since '85 our state has had a law which is equitable. But many states still have laws that require different training and experience for foreign graduates than they do for American, and there's been a lot of lobbying saying that's inherently unfair, that the FLEX exam was harder than the national board exams. Well, that had been looked at by a number of experts in education, and there was no evidence it was harder or easier. But even that argument is no longer showing up in court suits. Now, everybody takes the same

exam; that argument no longer applies. And my guess is that many, many more states are following Nevada's lead and putting in at least two and sometimes three years of graduate residency for all physicians, not just foreign graduates.

How do they protect against fraud in a computer-generated exam like this?

That's a good question. I think they're doing it now with picture IDs and fingerprints. I'm not sure, they've got a very complicated system. God, I think the national board went out and hired a bunch of retired FBI people and others to do it. There have been people who have come in with fraudulent credentials. There're still places around the world, I'm sure, where you can get very good forgeries of all sorts of papers. You still have to now get into the licensing exam, and in America you've got to get into residency. Prior to 1985 in Nevada, you had a year of internship someplace, and you had all the credentials; it was very hard to prove that you did or didn't get your degree from a medical school in Manila or a medical school in Mexico or other places.

As you probably know, in the public record, the Board licensed someone back in the seventies where it was demonstrated that the physician had obtained fraudulent credentials, we think in Los Angeles, claiming that he graduated from school in Mexico. We sent an investigator and an attorney to that school, and they could find no evidence that he ever went there. In that school, on graduation day, which is kind of interesting — the old European system, but this was in Mexico — on graduation day the graduate would come and sign his name next to his printed name in a book. We don't have that anymore in our country, but a lot of foreign schools still do that. In the year he said he

graduated, there was no signature, and there was no way he could have forged a signature. When he was confronted by Dr. Maclean (this was before we had the open meeting), he admitted he had been a corpsman during the military, during the Second World War. He was a bright guy. He had practiced in Las Vegas for a couple of years. But when he was confronted, he admitted that he had never gone to medical school, never graduated; he had gotten these fraudulent credentials from some counterfeiter in Los Angeles, and he had fooled everybody.

But that was in the day, when he got his license back in the late sixties, early seventies, that we had one secretary in the office. There was no way of checking on a lot of this. It was very difficult. Now, of course, there are so many checks and balances that many of our critics like to be critics of the Board. Even some physicians say, "Why does it take so long to get a license? And why do you check practically my birth record and everything under the sun?" Well, the reason is when you've been stung once and had fraudulent credentials passed through, you're much more serious. Nationally, the Federation is more serious about their credentialing; there's a lot of checking.

We, for example, no longer accept anything sent to us by the physician. We want original documents from the school or from the residency. We're not calling you a liar; we're simply saying that we've been stung, and we want to see the original — not your Xerox copies that you can make down at Xerox. One of my jobs here at the medical school, actually until recently, as the dean for alumni affairs, was to verify who they are — because I know every student that's graduated from here. I've got pictures of every one of graduates. So the Board — our Board or any other board — can write in here, and they'll send a picture of the

person, and they'll say he graduated in 1982, and we open the book and say, "Yes, there he is. That's him. Yes, he graduated, and that's his signature, and we got his records." I then verify that that guy graduated from our school in 1982, and that goes to the California board or to the New York board or wherever he's applying. And every school does that now, so that he can't forge his picture and he can't forge his signature. It's almost impossible. And they get it from the school directly, not from his representation.

This experience we had in Las Vegas with this one physician taught us that lesson. That lesson's been learned by lots of different boards around the country. Now I think it's very difficult; I think it's close to most impossible now to get a license with forged credentials. We've had a few problems with that for schools that were perfectly legitimate, that had been closed because of Third World problems. You can't get information from Tehran anymore, at least now. You can't get information from Baghdad. You couldn't get information until recently from Russia and Poland. So there're a lot of places where legitimate physicians got out during the war or after war, got trained in England or France or whatever, and got legitimate training, who were unable to get the documents. We dealt with that in a few instances, where he or she — the monkey's on their back — has to go and find three people who attended that school, who now are licensed in this country to give us affidavits that, yes, that person was in that school. But even a lot of that now, I think, is superseded by the issue of the USMLE and residency in the United States and Canada. It's easier, of course, to check on their training.

What about privacy issues regarding school records?

The physician is the one who's asking us for a license and he signs a release. It's a privilege; he's not entitled to it. The state of Nevada gives licenses to physicians as a privilege, and they administer that through a board that they set up by regulation and by legislature. So if the physician wants to get a license, he first of all has to acknowledge all of his past, because falsifying information is grounds for taking away his license. He has to tell us about his past, even if it's painful. Now, that's confidential to us; it's not public; we don't tell anybody about it, but it's part of our decision-making process. Also, he has to sign releases, and he does when he sends in the application. He has to sign a release to everyplace he's ever been on a hospital staff, everyplace he's been on a medical society, everyplace he's gone to medical school, everyplace he's done a residency. He gives those people permission to send that information to us. That's not public.

The fact that he has a license is public, but all that background information is in files we keep confidential. If in there there's information that we need to know about or question him about, we have the right to question him, and even to deny a license. So what we advise any physician applying to any state, not only ours, is be forthcoming; fill out all the forms; don't hold anything back, because if you get caught lying, if you deceive the Board, immediately that's grounds for revocation of your license.

I noticed, looking back at the minutes in the late sixties, early seventies, that you had added to the application whether or not a physician had ever been convicted of something like moral turpitude or a morals charge. So it's kept up with the times.

Yes, that has, and then later it became alcohol and drug abuse, and then, of course, disciplinary actions and hospital privileges or actions by hospitals. We even ask for disciplinary actions in medical school, because it all leads to the issue of integrity and moral turpitude. Now, with the Americans with Disabilities Act, we had changed that, because you can't under federal law ask people about past disabilities if they have been in treatment, and they're no longer disabled. So I can't ask you about the past, but I can ask you, "At the present moment are you impaired by drugs or alcohol or that sort of thing?" So the ADA, the Americans with Disabilities Act, a federal act, what? a year or so ago, prohibits anyone from asking about your past if that's past history, truly, and you're no longer impaired or sick or disabled. That's what it has to do with. It was to prevent discrimination for past disabilities. The fact that I was disciplined in medical school, let's say, for an example — I wasn't, but let's say I was disciplined for an alcoholic binge, or I got caught with marijuana, and I got into treatment, and I haven't used that stuff in ten years; you can't ask me about that ten years ago. But you can ask me now am I using alcohol now, or do I use drugs.

Now, that's for disabilities which deal with medical illnesses, but we can certainly ask about your criminal record: Have you spent time in prison? Or have you had ten DUIs?

But you can't legally ask a physician if he had a problem with chemical dependency . . . ?

In the past. We ask him does he have it now. Or is he in a treatment program now? Well, as you know, many physicians may be in treatment programs for seven or eight years, so they'd have to answer that question yes. But if I was in a treatment program from 1972 to

1976, and I've been sober for fifteen years, you can't ask that question, nor do I have to answer yes, nor would I be guilty of lying to you.

Our attorneys, following federal law guidelines from the U.S. Attorney's office have now redone our application, so that it conforms with federal law. And I don't have any problem with that. I mean I don't really care about your past. If it had to do with losing your license, yes, that's permanent. If you went to prison, that's permanent, and you had ten malpractice cases, that's permanent; but that's a different issue than your personal health history or disability. I think a lot of that was put in for drugs and alcohol and for people with HIV infection, too, and probably other disabilities, as well, you know.

HIV is something that the Board has had to deal with.

Yes, that's right. The question there was, of course, what would we do if we were told, because of the Kimberly Bergalis thing with the dentist, that a physician was HIV positive. As far as I know — the statistics still are the only evidence in the literature — is that she's the only one yet, I think, who has been demonstrated, she and five others, to have gotten their disease directly from the same dentist. There's been a lot the other way; there've been a lot of health care workers, including physicians, who have gotten HIV from their patients.

But we still dealt with it. We wanted to be prepared. What would we do if we were told a physician, licensed by us, was HIV positive? So we established regulations that would essentially form a committee of experts — three or four physicians in the state who were expert in the disease of HIV or AIDS. Any physician licensed in the state

gives a waiver to the Board to be examined at anytime, if we have reason. We'd have to have reason; couldn't do it arbitrarily. But if we think you're impaired, and your patient calls and says you got alcohol on your breath, we'll send our investigator over and get a urine from you, whether you like it or not. Refusal is tantamount to saying, "I'm guilty." So the Board has authority.

In this instance we would set up for HIV and AIDS a panel of experts. They would review the disease in the specific physician in question, review the nature of his practice, and then make a recommendation to the Board whether or not his or practice should be limited. A psychiatrist who doesn't have any contact with the patient's body systems is not going to be a threat to anybody. But if you're a chest surgeon or a gynecologist who's doing a lot of surgery, where it's possible that you will bleed, and there's blood in the patient, then you can transmit the virus. As I understand, under present CDC guidelines, you would be advised and told not to do that — change your line of work or do something else. So we've established those guidelines for that purpose.

You say "advised," but can you do anything legally?

Oh, sure. We can just say, "You will no longer practice that medicine because you're too high a risk." We would first talk to the physician, say, "We would like you voluntarily to give up that practice; take a leave of absence; get yourself under treatment. And then if you're in a practice which the CDC calls high risk, change your practice; go back and retrain, do something else." If that disease affects the patient's health, as it does, then we may expect that physician to be monitored. We set up a procedure so that committee that I mentioned would monitor that physician's

practice and his or her health on a monthly basis. If anything changed, then they would inform the Board, and, yes, the Board would have the authority to limit or revoke a physician's license or put them on a leave of absence until they change their practice. Anything that we'd have to do, whatever was required, to protect the public, would be done. The best extreme example I can give is the psychiatrist with HIV is of no threat with his patients, as long as he doesn't have sex with his patients. But that's another issue . . .

In 1987, the Board began sharing a lobbyist. Over time there is an increasing complexity in the Board trying to deal with the legislature.

Absolutely, and I can understand this; there are lots of individual groups who have issues with the Board. They don't like the way it's run, or they have their own issues of freedom, or issues of civil rights, or they want exemptions, or they want whatever. It goes from everything to "Get us a doctor in a small community," to "I don't think the Board should have any right to discipline me; I'm a free spirit," or whatever. There're all sorts of issues, and they lobby like everybody else.

Then there are legislators who come in with a vision of what ought to be done to solve the medical malpractice crisis, or what ought to be done to reduce the cost of medicine, or what ought to be done to increase the number of doctors in rural communities. They come up with their ideas, and they put it in a bill. Although the Board is doing its job as they see fit under the law, at every legislative session there may be bills put in by all sorts of people for all sorts of reasons — agendas that are hidden as well as open. The Board needs to, first of all, keep the legislature informed, regularly, about what we are doing. Also to ask the questions, "What is the motivation

for this proposed law change that we would have to administer? What would be the effects upon us?”

To just keep track of all that, we have to have somebody who understands the legislative process, someone who can monitor any bill that has anything to do with the practice of medicine or the licensing or the disciplining of physicians. I'll use an example: somebody came in and convinced the legislature that the Board should be prohibited from disciplining a physician who had sex with his patients. Well, that's an absurd example, but somebody might say, "Oh, sex with a patient might be therapeutic," or who knows what.

As a Board, if we're going to have our responsibilities and authority limited, or expanded, then whoever's proposing that legislation has to know our attitude about it. The Board has to know what the effects would be and be able to respond to that. So we then started with a lobbyist, if you call it a lobbyist, or a consultant. When we went for the '85 law, that was the first time we actually had a lobbyist, because we needed someone who would call me or Dr. Jacobs on the phone and say, "They're going to hear your bill next Tuesday at eight o'clock. You got to be here." Well, you got to change your schedule; you got to be there. The Board needed someone who would follow that, someone who could put us in touch with the committee chairmen and the people who have an influence on whether or not it passed or what information they needed. Also to make it clear to members of a particular committee hearing a bill that that bill is not supported by the Board — "These are the impacts it would have."

So we started that in '85 when we went to change the law, and we found it was very valuable then. We've also found in the past . . . and you raised earlier the issue of Gerovital;

you raised the issue of acupuncture; I raised the issue of physician's assistant. Anything that's going to change the law, the Board at least ought to have a voice to report the positive and negative impact of the change, to indicate if it will result in more or less work for the Board, or inhibit the Board in some way, whether or not it will change rules or regulations, or put Board control under a state agency, or take Board money and put it into the general fund — whatever. There are states in the country where the medical board charges physicians a fee, that money goes into the general fund, and then the legislature gives back to the board. In California, for a while, it was like seventy cents on the dollar. California's board didn't have enough money to do its work, and they were being criticized for not doing their work.

A good politician, I guess, down there, who became the head of the California board, pointed out to his colleagues, "You can't criticize us in the press and say we're not doing our job, and we're not disciplining lousy doctors, and we're not keeping bad doctors out, if you don't have the money to supervise and to monitor seventy thousand physicians in the state of California." Well, no. There's seventy thousand licensed; there's maybe thirty-five or forty thousand who practice there.

Why the discrepancy of numbers, do you think?

Oh, most physicians have two and three licenses typically. That's becoming less common, but I had my license in New York and Pennsylvania and New Jersey, and I let them lapse years ago. I didn't want to bother sending the money; I never intended to go back there. If I did for some reason, I'd go get it back, I guess. So right now I have a Nevada license, and that's sufficient for me. There are

physicians who practice in California, who have a Nevada license; maybe they live in Truckee, and they'll come over here and see patients. Or we have people in Reno and Las Vegas who have privileges up in Susanville or Tahoe or Bishop, and they go over and see patients there, or they go over and operate. Particularly near state borders — Utah, for example, and Ely and Elko — physicians hold state licenses at least in two states — Utah and Nevada, or Nevada and California. I think we have about twenty-four hundred physicians now practicing and living in Nevada, but we've got another, oh, four or five hundred physicians with active licenses who live in California, Oregon, Nevada, Utah, Arizona; and many of them will come over and work here for various things — come and consult. The medical school has a number of consultants who come up from UC Davis. State Health Department has a physician who comes from Oregon with some unique things.

Physicians generally in the past have gotten two or three licenses. They might have trained in California; they kept that license. Then came to Nevada; they kept that. Then they ended up in Utah, and they got that. And they just paid their fees and kept their licenses, hedging, "Maybe someday I'll want to go back." It's a lot easier to hold onto a license for reasons we talked about earlier. It's a lot easier paying a fee, and then keeping your nose clean and not having trouble keeping a license, than to let it lapse and then go back and try to pick it up. Particularly in today's world, where if you let it lapse and then go back to try to pick it up, that state may say to you, "Well, now you got to take some exams, or you got to do other things," so a lot of physicians will hold onto two or three or four licenses.

A couple of the physicians I've talked to mentioned, and you mentioned, hanging

around for a week to get a license. The Board meets at certain times, quite frequently now, but in the past they did not. So that leaves a physician in limbo.

It did up until last July. That's a good point, and it's important for the record. As you know, yes, we had six or seven meetings a year. We required the physician to come; he or she was interviewed personally and had an exam that they took — oral exam. We went back, and we looked at the last four or five years, and the last thousand physicians who came and went through that process. None of them were denied. All the denials had been prior to the personal visit and the personal interview, because their credentials were not in order. So we found that as we got better with the credentialing process, fewer and fewer physicians really had to show up to be eyeballed and talked to and given an exam. In June we suspended the routine visit of physicians to Nevada and the routine oral examination. We still have the ability to specifically, on a case-by-case basis, invite a physician to be examined, but routinely we've stopped that. Now, beginning in July, we have instituted a process whereby when all of the credentials are in order by one of our three licensing specialists, who are experts in this, that information is put on the desk of Mrs. Perry, our executive director. She reviews it. If she finds no problem, she signs off on it. It then goes to Mr. Lessly, our attorney, and he reviews all of the legal documentation; he signs off on it. It's then put on my desk, and once a week when I go down there, like I did this morning, I sign off on it. This afternoon our licensing specialist will call nine doctors telling them their license was just given to them. I signed it the day their license was issued. If there's any question by the licensing specialist, by Mrs. Perry, Mr. Lessly, or myself,

from four independent reviews We do not sit in the room and review it together; they're independent of one another; there's a checklist we go through. We don't talk to each other; we try to independently make our own judgment. If any one of those four people feel there's a problem, a question, anything, it's put on the next agenda for the Board. So Friday, when we meet in Las Vegas, I think we have three or four such applications, which the entire Board will review.

What types of problems prompt this review?

Past history of felony convictions, a physician who's still in an active alcohol treatment program, which he told us about. So that the Board, then, has to look at any questionable case. But what that's done is that's allowed us to provide that roughly 95 percent of all applicants can now get their license within four to six weeks of the time they sent in all their paper. There's still that issue of getting all the credentials in. But they don't have to wait. So let's say, in the past, if you got all of your credentials in on March the fifteenth, you had to wait till June the tenth. If you got all of your stuff in on June the fifteenth, you had to wait till September. Now, if you have all your stuff in on June the fifteenth, you can get your license by the June the twentieth or thirtieth, as soon as everything is processed. So we streamlined that process. We still reserve the right to see any physician we want to, any questionable application with any questionable information where any of the responses are yes, "Yes, I, you know, have this, that or the other on my record." Those are all reviewed by the full Board at the next meeting. So there will be about 5 percent of the physicians that we license — now about three hundred doctors a year — roughly fifteen or so, twenty, who will have to wait till

the next Board meeting for the Board to make the decision. But the other 95 percent will be really expedited, and the criticism about wasted time is no longer valid. We get licenses now to physicians as fast as any state in the union, but we still have a process to catch the small number that we're concerned about.

For a while, Nevada was testing by specialty in their oral exams, and there were complaints that they were too hard. Then you went to a general exam, and everybody was passing it.

Yes, that's true; that's true. But that came from our understanding of what was going on with the USMLE. It also came from what I talked about earlier. We are a Board, as in all states, that grants a general license; we don't license by specialty. I could do neurosurgery if I wanted to try; I'd be crazy to do it. I could do obstetrics. I could do anything. Mine is a general license for medicine and surgery. OK. We learned from the USMLE that there's a minimum standard that you set by asking general questions of all future physicians, not specific questions to the neurosurgeon, other questions to the orthopedist, another question to the urologist. Those are specialty exams that a board certification exam ought to address. But the licensing board ought to simply be able to say to the public, "This person has passed a general exam of general knowledge at a level you'd expect all competent physicians to pass." The only people it would pick up is people who are incompetent or mentally incompetent or senile, or under the influence of drugs or alcohol or anything else.

So we then shifted and said, "Since we're giving a general license, how can we give a very detailed specialty exam?" We couldn't justify that; we really couldn't. It wasn't so much that they were tougher exams, and we had no motivation to keep doctors out of

Nevada — hell, we wanted doctors to come to Nevada. We just wanted to be sure they were basically competent.

So we then went to a general exam where everybody that week, just as I'd suggested at the USMLE, which they take in written form — everyone who came to that examination session would be asked the exact same questions. We did that also on the advice of our counsel that you couldn't discriminate that way. If everybody was asked the same questions, no one could leave the room and say, "Well, they flunked me because they asked me harder questions than the other ten people." So we then had standard exam questions, and we had examiners who asked them the same way, and they had answer sheets. But they were general questions. We feel, for example, to be competent today, every physician ought to know something about HIV infection and universal precautions and how the disease is spread and how to protect against it — that'd be one. We think every physician ought to know such things as informed consent — what is necessary when a patient gives you consent to take off a leg, or take out a lung, or treat them with a potent drug. Every physician ought to know what the law says about reporting communicable diseases and gunshot wounds. So we put in questions from the law, which, of course, they all got in the mail a week before and were told to read coming out on the airplane. We did a lot of those things, which were basically to set a minimum standard without looking at specialty, because we didn't license by specialty.

Well, then we found that practically all the physicians who met all of the paper credentials and were invited to come to interview were passing the exam. That made sense because we'd already picked up the ones who were having problems or who had failed

other exams, and we didn't even let them come. So it streamlined the process, but we also feel it's more defensible for a licensing board that gives a general licensing exam.

As I said, a licensing board can't set optimal standards. How are we going to say, "What's an optimal doctor? Are we only going to let the best doctors practice in Nevada? Well, how are we going to define that one?" That would take us forever to do. Although we all have some intuitive, internal sense about who are good doctors, or who are the best we'd like to go to, you can't have a state agency licensing people that way. I don't know how it could be done.

Dr. Scully, one of the things that I did want to ask you about was the investigative committee. As secretary-treasurer, you're head of the investigative committee. We've referred to it a bit in the past, that the individuals who were on the investigative committee don't vote and that sort of thing. But I'm really interested in the whole process of investigating a physician.

OK. Prior to 1985 that role was vested in the secretary-treasurer alone. It was always Dr. Maclean for years. He would give to the Board a capsule idea of what the problem was with the physician in question. The Board with inadequate information would then vote under statute to file a formal complaint. Before the open meeting laws in the late 1970s, that was just done by the Board calling someone in. Then when the Open Meeting Law started, the complaints had to be in open and they had to be heard in an open session. Well that put an enormous amount of responsibility in one individual, and when Dr. Maclean retired from the Board, I took over as secretary-treasurer. I and other members of the Board felt it was an appropriate time to ask the legislature to change that because we really

thought there should be more involvement of Board members in the initial decision whether or not to bring a complaint against a physician, because once you do that and it's in a public arena, that can be quite devastating to a physician's license, particularly, and to his practice and reputation, especially if it was done without a lot of thought.

So we went to the legislature in '85, and my testimony, which you have, will give all the details. We went and said we wanted to enlarge the Board, and, furthermore, we wanted to have the opportunity to investigate and file complaints by a committee. Mr. Lessly was our attorney, and he wrote all that part of the law with the Legislative Council Bureau. I then resigned from the Board in '85 and was off till '88, but my successors, Dr. Clift, Dr. Avery, and Mr. Lessly and others implemented the investigative committee, which at that time was the secretary-treasurer, a physician, and one other physician, usually from the opposite end of the state (Las Vegas in this case), and one public member. They then did the investigation along with our full-time investigators and an attorney that we hired, and the three of them would then bring to the Board the complaint, having reviewed all of the relevant information.

At that time the Board still had the authority to file the complaint formally, but then about 1990 — I think it was in 1990 or 1991 — we then, with further legislative clarification, established that the committee itself (Mr. Lessly can clarify the action at that time) would have the authority to file the complaint. The other members of the Board would not be privy to any of the information at all. They would know nothing about it until the complaint was filed. Then the other members of the Board would serve as the adjudicating hearing body that would make a judgement about the physician's guilt or innocence, and

in that circumstance the members of the investigative committee would be prohibited from any further involvement. So it really separated out, I think appropriately, the responsibility of bringing complaints against a physician and the responsibility of hearing the evidence and arriving at a decision, guilty or not, then imposing whatever sanctions should be brought.

We've now been doing that for a couple of years. It's worked very well. It's very much like a grand jury, jury system in the public arena. We now have four members on the committee. We have, as you know, a nine-person board — six physicians and three public members. So we have four members of the committee — that's three physicians and one public member — who do the investigation, file the complaints. The other five then adjudicate the complaint at some subsequent time. And many of our adjudications, as you know, are done before a hearing officer, so that those other five members don't actually sit and listen to all the evidence. The hearing officer sits, the two attorneys, defense and prosecution, bring their case before the hearing officer, with a transcript, and then that is reviewed by the Board that then makes a decision.

We decided to go with four because these complaints are getting more and more complex. We felt that at least three of the four members would have to be convinced of the nature of the offense and that it sufficiently violated the Medical Practice Act. We don't file a complaint just on the first complaint; it usually has to be gross or repeated, more than one repeated malpractice or other transgressions. That way at least three of the four members have to make a majority by voting in confidence, a confidential hearing. All of the investigations are private and confidential by law. The investigative committee meetings are confidential and

private by law. Only when they file a complaint does that become public.

So we think that we have, first of all, safeguarded both the public safety as well as safeguarded the rights of physicians from undue bias of one kind or another. My experience in the last four years since taking over the responsibilities as secretary-treasurer again, I think without exception, when the committee has decided to file a complaint, it's been unanimous. Usually if there's sufficient doubt in the mind of any committee member, then usually there's sufficient doubt in several committee members' minds, and nothing goes forward, and we'll frequently wait until subsequent complaints are filed.

If, in fact, a physician's behavior is such that he is repeatedly violating the law in one way or another, usually that comes to the fore. It's unusual that we would proceed on the basis of just one case, unless it was so gross and so egregious that no one could possibly ignore it. But usually you're talking about one case being reviewed, it being put on file, and then when a second or a third or a fourth case of similar nature comes forward, then usually we'll file. So that's the general process. That committee meets about ten times a year. It's usually an all-day meeting. It's often in conjunction with the Board meeting, the following day, but we meet usually five times in Reno, five times in Las Vegas. We call physicians in as a part of our investigation. We have three consultants who review all the records and give us recommendations. We then review and file complaints. Last year I think we reviewed something like six hundred complaints against approximately four hundred physicians. Some physicians we'll get two or three complaints against. Some of those are not under our jurisdiction because they are issues of demeanor or accusation that the physician is rude or fee disputes — we

have no jurisdiction over what you charge your patient unless the physician bills for services not rendered.

There're a lot of things that the public thinks we ought to be disciplining physicians for which we have no jurisdiction; we're limited to the law of the NRS 630 that you have, and our attorneys are the ones that say whether or not a particular offense is within our purview. Sometimes it's SIIS or it's the health department or it's some other group, and we will refer the complaint on to the appropriate authority.

The committee probably reviews in the range of about four hundred complaints. That process is interesting, and we try to make it as fair as possible. A complaint against a physician in Reno or other northern communities is reviewed by a consultant in the south and vice versa; a complaint against a Las Vegas physician is reviewed by a physician in the north, hoping that, and in most cases is the case, the physician reviewing the complaint does not know the physician in question.

So they know the physician's name.

That's all they know. Yes, they know the name, and they have all the complaint in front of them. Now, if they happen to know who the physician is, then they will disqualify themselves. But we have several physicians who are very good. They review the complaint. They give to me an opinion about the medical issues involved. I review that with our committee. Then the committee, which I said earlier is three physicians, decides whether or not there's sufficient reason to go forward. So, when you think about it, there's one or two reviewing physicians. Interestingly, if the reviewing physicians or I believe it's gross malpractice and feel that a complaint

needs to be filed, then we'll go out and get even two or three more peer reviews done by physicians at the other end of the state who are in the same specialty as the physician in question. Occasionally if a physician is so prominent that everybody knows him, we will go to California or Utah and get an outside-the-state peer review. So, in some instances, actually most instances before a complaint is filed, it will have been reviewed by one or two consultants, myself, two other physicians on the investigative committee, so that's five physicians looking at it from the medical viewpoint, an attorney, two investigators and a public member of the investigative committee. So there're usually nine, and, of course we can consider our investigators public members in a sense. They are people who look at it from the standpoint of the public. Plus the written complaint of the patient or his or her family and the response of the physician in question. So there's usually about, oh, ten, eleven, twelve people who have independently reviewed whatever the complaint is. And as I said earlier, usually when the committee then files a complaint, there's a fair unanimity of opinion, or at least a consensus. Then, after the complaint is filed, as I said, it's in the hands of the rest of the Board. The committee is out of it. Some of those physicians who reviewed it on our behalf, those consultants, may actually then be called back three, six, ten months later to come and actually testify at a hearing. When the committee finds no basis for filing complaint, they're closed and the physician and the complainant both get a letter to that effect. Although technically nothing is permanently closed because we keep every complaint on file, so that if there is a pattern to a physician's behavior, it will become apparent over time.

You said something about reviewing relevant information. What kind of relevant

information? What are they looking for, the investigators, for example? How do you avoid a witch hunt on a physician?

Yes, that's a good point. First of all, we take no anonymous complaints. They call here and tell us, and one of our investigators will frequently start the investigation by listening to someone over the telephone. The investigator will tell them clearly that if you are unwilling to put this in writing and sign your name to it and be prepared to testify in a public hearing, we will go no further. So we take no anonymous complaints, nor do we follow through on a complaint where someone says, "We just want you to know about Doctor So-and-so, but we are not willing to stick our neck out, and we are not willing to testify." Very nice, but we don't proceed, because if the complaint is filed by someone and it's in writing, they have to be able to stand by their testimony in an open hearing and be cross examined by the physician in question or his attorney; that's due process. If the complainant is unwilling to do that, then we say, "Well, you may have a good complaint against the physician, but you got to put your money where your mouth is." So that cuts out a lot of so-called witch hunts or anonymous complaints or complaints that there was no one else in the room, and it's my opinion against his. Is that going to hold up? So we never go further.

But if they then say, "Yes, I am so angry, I will testify if called upon. And, yes, I will put my complaint in writing, and I will give specific names, dates, times, places, offices, hospitals, locations, et cetera," and that becomes the substance of our investigators complaint. We have the authority under the law to go to the hospital, get all the medical records that're relevant, go to the doctor's office, get all medical records that're

relevant, go to the medical legal screen panel or to the local courts and find out all malpractice adjudications against this physician. Anything which is in the public record is relevant. We then talk further with the complainant and any one else that they tell us to, "Yeah, the nurse saw it," or someone overheard the conversation; then we go to the physician himself or herself and give them the opportunity to put in writing the response to the complaint, and they usually do when they send us their records. All of that then becomes the body of paper — sometimes it's mountains of paper — that then goes to our consultants. Consultant then reads all this and says, "I don't see any violation here. I think what this person did was perfectly legitimate medicine. It was within the standard of care," or "No, it's not within the standards of care." Then all of that information comes back to committee. So that is the process; we don't review or will not follow through on anything which is anonymous or if the complainant refuses to testify, and they are told that up front.

Do you have physicians who will file complaints against a physician? For example, if they saw something in the operating room?

What usually happens in the hospital is if a physician breaks some hospital rules, that usually is reported to the chief of staff of that hospital. He or she will then investigate within the institute. If they take disciplinary action against the physician within the hospital, limit his privileges, for example, they are required by law to report it to us. So hospital chiefs of staff and administrators report complaints against physicians to us, based upon some action taken in that hospital. In an office setting, where there is no formal administrative structure, we occasionally get complaints from colleagues, but I must

say that a relatively small percentage come from physicians. The exception is the hospital chief of staff who is obligated by law to do it. Most complaints come from patients, patient families, some nurses who work with the physician or see the behavior of the physician, social workers, others. Physician's colleagues generally are very late to report and I can't give you an exact percentage; my guess is it's probably less than 10 percent of all the complaints.

You mentioned during the Board orientation that the most common complaint was on the fees, which is not in your jurisdiction. Of the complaints that are legitimate, what is the most common complaint? In reading over the Board notes, they use terms like impropriety or gross negligence, which means nothing to a public observer.

Correct, right. A fair number of complaints are complaints about demeanor, I guess you would call it, where the patient says, "The physician didn't listen to me, was rude, threw me out of his office," or an issue of informed consent, "He didn't really tell what he was going to do; I didn't realize that I was going to have a scar after he did the surgery." A fair number of complaints we get from women, particularly from women alleging that men have been improper in the examination of woman's breast or doing the vaginal examination, have no witness in the room. It is hard to judge from the interpretation of the woman, what in fact he was doing in examining her breasts or doing a pelvic examination. Those are two examples we see that a lot.

There are then issues of frank malpractice where a physician failed to inform a patient, a physician got into a complication in surgery, failed to recognize it, and the patient then

had complications after that. Those make up the majority of the complaints. But I would guess, other than fees, the most common complaint is basically demeanor; doctor-patient communication is the best way to put it.

This isn't really the Board's jurisdiction?

Well, it is to an extent, and we do often bring in the physicians to talk to them about it, because it might suggest that the physician is impaired; it might suggest that he or she has a problems with drugs or alcohol. We always look at what may be the hidden, underlying agenda, because not uncommonly we uncover a physician who is impaired by drugs of alcohol by his behavior. He is not necessarily smelling of alcohol in the office, but his behavior is quick or short or whatever, or possibly a physician is depressed. We do have jurisdiction over a physician if he is incompetent by virtue of drugs, alcohol, mental illness, depression, whatever. So we do pay attention to that. We don't have jurisdiction over demeanor, but we certainly bring that to a physician's attention. So those are the various categories that we get into.

When you have a case of substance abuse and a physician is in a program with you, you can do spot checks, urine analysis. How long are drugs or alcohol detectable?

Well, it varies, depends on what drug are you talking about. That's why our urine tests are always random, and we do occasionally get blood tests for that very reason. Some drugs are not really detected well in urine, but let me go back. When we meet with a physician who has been reported to us as having a problem with drugs and alcohol, after he or she has been evaluated and they go into

drug treatment program with the physician's assistance committee, they sign a confidential stipulation that if they violate any of the rules of that stipulation, they realize then they will have a public action brought against them. Many states have adopted the ability — and our state has, too, through our legislature — the ability to intervene with the physician early in his illness before it's public, in the hopes that you can get physicians voluntarily into treatment before someone actually gets hurt.

If your approach is only punitive, as it was in Nevada prior to 1985, and as it was in many other states, the problem goes underground. Family members and employees become enablers, and they protect the physician. People would not report it for fear that the physician will lose his livelihood. Studies in Oregon prior to 1985 indicated that when a physician was disciplined but not offered any help by his colleagues, they have a very high suicide rate simply because a physician's license is one of the most important pieces of self identity, I guess you can call it. So because of that experience and the development of voluntary programs, our state and many other states have developed voluntary programs. In that program the physician volunteers to go into treatment and stay in recovery. He then signs an agreement that he or she will give our investigators, on demand, random urine samples, at any time. We don't tell the physician when our investigators are coming by. They might come by evenings, mornings, weekends, weekdays any time because you have agreed not to use that substance, whatever it is, alcohol, for example. Now, I am sure that a real risk taker would say, "Well, the investigator was by last week, you know; maybe I can get by drinking for a day or two," but remember many of these physicians are also involved in AA, and they're

seeing colleagues. But our investigators, through our executive director, set up a very random schedule for urine. We might go see a physician on Monday and be right back there on Wednesday, and then not see him for three or four weeks or a month. Generally we are seeing them once a month and getting a urine on them, but it's very random. Might be Monday morning one week, Friday afternoon the next week. It might be a Monday morning and Tuesday afternoon right in a row. Specially if our investigators go, and the physician is showing any sign of being distracted, being depressed, not making eye contact with our investigator or not keeping their personnel appearance up — you know, they are looking slovenly. Something that would suggest that they are relapsing.

In addition, we have direct contact and a liaison with the physician's assistance committee, so if they see a physician who is in recovery, relapsing in some way or another, they will intervene. They will call me on the phone, and I will intervene. It's a volunteer program, but I call it a carrot-and-stick program. The carrot is, "Yeah, if you stay in recovery and voluntarily take care of yourself and avoid drug habituation, you won't hear from us, but if you don't, you will hear from the Board." So we are more or less the stick; we are frequently the bad guys. The work of physician's assistance committees or the colleagues who are offering help has worked very well not only in our state, but many other states.

Do you get advice, for example, from counselors or psychiatrists or psychologists that they are seeing, to determine if it is safe for this individual to practice?

Yes, you are absolutely right. As a matter of fact, when a physician is first uncovered,

almost always — not all but almost always — they go away anywhere from one to three months for an in-patient program either in Georgia or a program up in Oregon. There are other programs in California and Illinois where they actually go as in-patients for one, two, three, four months. During which time their entire addiction is explored, and they, of course, are detoxified if they're under the influence at that time. They go through extensive evaluations by psychiatrists and psychologists, and their family members will be involved. They then get hooked up usually with AA or Al-Anon or narcotics anonymous, various self-help groups.

Then we have the right under the law to require a physician to go to on-going counselling. For example, we could say to a physician, "You shall see a psychiatrist every month dealing with whatever your behavioral problem is. As a matter of fact, in order to keep your license, you will agree and give permission to that psychiatrist to send our Board confidential monthly reports about your progress." That's all perfectly legitimate and appropriate under the law because the issue is whether that person is competent, and, yes, we've had physicians who had absolutely no troubles with drugs and alcohols, but we were concerned about their mental competency from mental illness, or who were getting older and outdated, and, of course, we had a number of physicians who we felt have not kept up. They had no problems with drugs and alcohol; they were perfectly alert, but they just did not keep up, and they were practicing medicine that was twenty years old. They were actually endangering patients by inappropriately using drugs or whatever, so we have in many instances ordered competency exams. Professional competency — I don't mean mental competency — where they are required to go and take an examination and

prove to us that they are capable of practicing modern medicine. So we've had a number of instances like that.

We have a broad range of ability with due cause — we can't do it arbitrarily — but with due cause to require a physician to go to a drug and alcohol treatment program, to take a competency examination, to enter into on-going therapy. We can limit people's practice so they don't have any direct access to patients where there have been allegations of sexual misconduct; we might require a physician to have a chaperon in their room at all times when seeing a woman — that would be an example.

What factors would contribute to making a decision about limiting a practice rather than revoking a license? As with Dr. Minton, for example, in Carson City, where sexual impropriety was one of the allegations. Why not assign a chaperon in a case like that when a man is apparently professionally competent but has a problem?

Oh, I think that was probably one of the options. I did not attend that meeting because I was on the investigative committee; the Board heard the case and I was excluded. Yes, that was one option the Board could have used. They felt, after hearing the evidence from all of the women, that the complaints were so egregious that his license should be revoked. I guess that would have been an option, if, for example, there were only one or two cases. In that incidence, as is my understanding, the Board felt that behavior was such a pattern, that his license should be revoked.

There are other examples, not him, in which physicians have had their licenses limited. We had one physician where there was an allegation — and remember, you are

innocent until proven guilty in this country — that a physician in Las Vegas was fondling young boys, and so we simply said he was prohibited from seeing anyone under the age of twenty-one until he has his hearing. He voluntarily, with his lawyer, agreed to do that.

I see, so you limited the practice until you can determine what is going on, but in the meantime you protect the patient.

Protect the patient. Oh, yes, absolutely. Our goal is to protect the public, and we can do that. We have to assume, however, that the physician is innocent until proven guilty given our system. If the complaints are sufficiently egregious, what usually happens is the committee calls the physician in, and the attorney and his attorney talk. They may say, "Look, until you have your hearing, we want you to avoid any instances where similar complaints can be generated. So from this point on, do you agree to a chaperon? Do you agree not to see any woman? Do you agree not to see any children under the age of eighteen or twenty-one?" I mean, there are a variety of things we can do, and usually in that instance, the physician will say, "Yes, until I have my hearing." Once they have the hearing, then it's up to the Board to decide. So, yes, we can do all that.

Let's assume a physician got into difficulty in surgery. He has done quite well in a variety of surgical procedures, but he has one problem with procedure X. He had three cases of malpractice all dealing with procedure X, whatever that is. We can simply say, "Until you have a hearing, you will not do any more procedure X. You can do Y and Z and A and D," and the physician usually will say, "OK, fine, I just will not do that until I have my hearing." Then, of course, if he has his hearing and he is found guilty of not knowing how to

do procedure X, he can be prohibited for life from doing procedure X. There been examples that I can think of with surgeons who have had specific limitations put on their surgical procedures. You could do every thing but _____. The reason for that is that the due process advice we get from our attorneys as well as from court cases around the country, is you can't really kill a gnat with a sledge hammer. You have to have the punishment, if you will, fit the crime.

So you may have a perfectly competent, maybe even gifted individual in some aspects of practice, but he needs to be aware that he can't do this.

Right. That's right and then you say, "The only time you got in trouble, Doctor So-and-so, is every time you attempt X, you mess it up. You either got to go back and learn how to do X the right way or just stop doing it." There have been a number of physicians who agreed to simply say, "Well fine, I won't do that anymore," whatever it may be. "I won't do caesarean sections because I have had too many complications, but I can deliver babies without caesarean sections." Or, "I will no longer do endoscopic surgery of the gallbladder because I had three or four complaints and complications; the hospital won't even give me privileges any longer. But look, I have no problems in doing good appendectomies and hemorrhoidectomies and doing other surgical procedures." The Board's position and the law's position, at least the law as seen by courts, is that you have to have some balance between what it is that you are accused and found guilty of and what the punishment is going to be.

Do you have the feeling that you are walking through a mine field?

Yes, and there are, I don't know how to say it exactly, lots of people who would not want to do this. There are a lots of physicians who think that we are too strict, that all physicians make mistakes. The public perception is we are too lenient, and the public frequently feels we ought to be more punitive. Why haven't you taken that physician's license away? Why is he still out there doing surgery? Why is he still delivering babies? Or whatever the problem is. We feel that in most instances, if not all, if the physician has redeeming qualities and abilities that those ought to be used for the benefit of the public. But the public has to be protected from his incompetence, whatever it may be.

The best example is obviously alcohol. If you have an addictive personality and you avoid alcohol, there is no reason why you can't practice medicine. If you use that drug, you are in trouble. If you are an outdated physician, who has chosen not to stay up to date in certain areas, then you have got to give up that practice. This does not mean they cannot do other parts of medicine.

One nice thing about medicine, I must say, is there is room for all sorts of people doing all sorts of practice; there are so many things you can do. The license is one of the last common denominators of a physician's livelihood, you know. He or she may give up all sorts of things and get into all sorts of difficulties, but they will struggle to hold on to their license because that is their livelihood. But it's also a very important mark of their self identity. It's a devastating thing for a physician to lose his license. So it's not something one does cavalierly. I think I have explained as

best I can, why we have tried to make it as thorough as possible and involve as many in the decision as possible.

There is a computer network, so, for example, Minton lost his license; now he is not going to be able to go to Utah and practice medicine?

No, or if he does, Utah can make their own independent decision; they have that right. Oh, sure, we've had examples of physicians who have lost licenses in other states, for whatever reasons. They come to this state, they have been to treatment of one kind or the other, they have agreed to limit their license, limit their practice in one way or another, and we've permitted them to be licensed. But they would be under supervision; they would be monitored. A lot depends on what you lost your license for in another state because not all states have a uniform law; not all boards are uniform in the way they administer their laws. Some states are much more lenient than the others.

If we could have a scale of leniency and severity, California seems to be the most strict right now. They are taking disciplinary action if you look at them cross-eyed. They're doing this because for years they were very lax, and they got all sorts of public furor over there. They actually changed their board, changed their administration, and a lot of other things.

There are other boards that traditionally didn't have the resources, or didn't have the interest to discipline physicians. They would be very happy to bring a doctor in and say, "If you just leave and go someplace else — why don't you go out west to Nevada, why don't you go out west to Utah; just get out of our hair — we won't bother you," and that was what went wrong for years and years and

years. A problem physician in Pennsylvania ends up in Oklahoma; he gets into trouble there; he ends up in Nevada or who knows where. There's no record; he just up and left, shows up and starts his whole procedure all over again, and whatever it is, and gets into more trouble.

Finally, for all sorts of reasons, not the least of which was public pressure, both in Washington and in each state, there was a movement about ten years ago to stop physicians fleeing one state and going to another state. To stop a board from letting someone just leave without any public record of a disciplinary action and hoping that, if that physician gets out of their hair, he's somebody else's problem; we don't care about him. Well, we felt badly about that, and I'm sure we were part of that through the years, historically. Certainly since 1980, we and other boards began to say, "Wait a minute, we've got to stop this. We don't want your deadbeats, and we're not going to send ours to you, and don't send yours to us." If someone violates your law, discipline them. OK. That's the first issue. Then, once they've been disciplined, they can still pick up and go to another state; there ought to be a mechanism for one state to know about the behavior of a physician in another state.

Until just recently, many physicians wouldn't tell another state about prior problems. Now, of course, almost all of us use a uniform application that's three pages long and asks all sorts of questions. If you lie about any answer, that is reason to revoke your license. So now we ask physicians about their problems in other states. But furthermore, if they were to withhold that from us, we check on every physician through a national data bank and a computer program run by the

Federation of State Medical Boards in Fort Worth, where if disciplinary action is taken against a physician by another board or by any board — and it's public, of course — that information is sent to that computer the day after the hearing. It is then in the computer for reference by any other board, should that physician go any place else.

It's been very effective. It's allowed our investigators to check on the past history of a physician coming to Nevada, and that way we get prior knowledge of a physician. He or she still can come and appeal to the Board and say, "Oh, I think I was unfairly treated in that other state. Here's my story." But generally, we can get all the documents. The computer program just tells us there's a record on file, so then we contact that other board and ask for their public record. We are asked frequently for public records on our physicians, and we just send it to the other board, and they can make their own decision. One board is not bound by the performance or by the decisions of another board. But it's been a very effective way to prevent "doctor-hopping," they used to call it.

Some people think that it's too severe and that it prohibits, you know, interstate commerce and prohibits physicians from pursuing their profession. Our answer to that is, "Yes. But if you have violated the state law in some other state, we want to know the nature of that violation. What did it entail?" There're a number of times now where physicians have gotten in difficulty with the law, but it didn't relate to the practice of medicine. Income tax evasion would be a classic example. Well, that's not a reason to prevent a physician from practicing medicine, unless you think that it's an indication of moral turpitude, I guess. But most boards, in my experience, and certainly our Board is very interested about any transgressions that deal with patient care.

Since Medicare has been in, there have been physicians who have been disciplined by the federal government for Medicare or Medicaid violations. We've had physicians who have gotten in difficulty prescribing controlled substances to addicts, not knowing it. All of those are violations of the law, but if the conditions under which that occurred are understandable, even though you may have been punished by the federal government or state government, that may still allow you to practice competent medicine as long as you stop doing whatever it was you've done. We've had physicians who are still practicing in the state, who have been fined for Medicare violations and been prohibited by the federal government from participating, for example, in Medicare and seeing any Medicare patients. The government just will not pay them for seeing Medicare patients. But they still keep their license, and they've been appropriately disciplined.

You mentioned moral turpitude. That's a very old-fashioned-sounding term.

Hard to define. [laughter] Very hard to define! It is probably in the eye of the beholder.

Back to Talleyrand and treason as a matter of the calendar?

Yes! [laughter]

Moral turpitude is a matter of the decade?

Yes, that's right. Sure, for example, many boards spent hours worrying about and dealing with abortionists before *Roe v. Wade*. They were called abortionists; now we call them gynecologists who do therapeutic abortions on demand. So a lot depends on the attitude of society and the law at the time. You're absolutely right

And you may go back to it ten years from now.

Sure! Right, exactly. We don't know. You see, also, it's very difficult for a board to put themselves in the position of being guardians of the morality of medicine. What they are is protectors of the public under a very limited law. I mean there might be lots of activities and behaviors of physicians that I think are reprehensible and unethical and morally unjustified, but they may not be a violation of our law. And for many people abortion might be that example; there're probably lots of others, too. You know, I think physicians should be polite and care about patients and deal with them as other human beings. So you can argue just being rude to patients is in itself a violation of the ethics of medicine, but it's not something that the law addresses or gives anyone authority to deal with. Moral turpitude? I can't define it, really. I'm not sure that in my experience in fifteen or sixteen years, that's ever been included in a complaint against the physician.

In line with issues of morality and ethics, how has your time on the Board affected your view of medicine and your fellow physicians?

Well, I think I was rather naive when I came on the Board, because I liked to believe the best of all of my colleagues and myself. And I think many physicians would like to believe the best. So I got to see some of the worst of my colleagues — a small number I say gratefully — whose behavior I just think was atrocious beyond any bounds of propriety, and inexcusable.

Frankly, with a few exceptions, I would also say — so it's really a double-sided answer — I've seen how good many of my colleagues are, what wonderful people they are, and what marvelous way they care for

patients. Their generosity and giving their time to help their colleagues, such as in the drug and alcohol programs. I also think that many, many physicians have been very generous giving their time free to evaluate other physicians, to look at the kinds of complaints we receive. They have honestly accepted their responsibility to participate in disciplining their own. There is a professional responsibility to not only set standards for your profession, whatever it is, but also to participate in improving it, to educate and to discipline those who violate the tenets of your profession. So I think a lot of physicians have been just wonderful. My esteem for many of the physicians in Nevada has gone up because of this experience.

Should we hold physicians to higher standards?

Yes, I think so, absolutely. They claim a higher standard; they take a Hippocratic oath. They claim frequently in the public that their education, their training, is longer than that of most professions. That they are required to meet a lot of ethical standards that other professions are not. That they will always act in the best interest of their patients. That they are not businessmen (many of them are actually, I guess, but they say they are not), and that their actions are for the interest of the patients and not their self interest, and they will put patients' interest ahead of their self interest. They are not selling a product.

Yes, there are a lot of things that in my view require physicians to hold themselves and the profession to higher standards than other professions. But I am not sure the public has to put us on a pedestal. I think it's our duty to do that ourselves, so it must come from within the profession. If we profess — which is what it means, to profess — if we profess certain things, I think we are duty bound to

hold ourselves to what we profess and what we say we are going to do.

I think because of that, the public, through its legislature, licensing laws and others, has given medicine enormous authority, enormous leeway that they don't give to anybody else. The very things that I do as a physician with a consenting patient, done in another setting could be considered as assault, battery, or rape. The public, in an individual doctor-patient relationship, exposes him or herself physically, emotionally, and psychologically to another person, expects that physician to hold all of that in confidence and to use that information, no matter what it is, for the benefit of the patient. So there is much in the ethics of medicine that I think requires us as a profession to hold ourselves to higher standards. I think then that there needs to be a Board of Medical Examiners, and medical societies and others that monitor what goes on in the profession. So, yes, I do.

This is a double question but a final question. Would you go into medicine again? And would you be involved with the Board of Medical Examiners again?

Yes, yes, I would go into medicine again. It's almost forty years now since I started medical school. There have been enormous changes. Technological, which I just mentioned, plus the changes in the way we practice. But the answer is yes; I can't think of another profession that gives anyone the opportunities to meet personal goals to be productive, and to help others. I think all of those are noble goals and achievable, and I don't think of any other profession that gives people that opportunity, so that's the first answer.

Secondly, I have two sons and a son-in-law in medicine and have never discouraged

them; I have always encouraged them. They are all doing well; they enjoy their practice. They are practicing in a different way than I did forty years ago when I went in, but I still think it's a wonderful profession.

Would I serve on the Board of Medical Examiners again? Yes, I certainly would, although I am glad I am getting off in another year, because I think . . . I frankly think that this is a responsibility that is a professional corporate responsibility, that the entire profession needs to be involved. I have spent a lot of time in my term as secretary/treasurer to get physicians involved. We've had hundreds of physicians throughout the state participating in one aspect of the Board or the other, whether it was licensing exams of physicians, or reviewing complaints, as we talked about earlier. And as I told you earlier, I'm very supportive of limiting the terms because, I think, more and more doctors need to be involved. But, yes, I would; I would do it again if asked. Not in this lifetime, but if I had to do it over again, is the way you phrased the question, I see nothing that has soured me on my profession or that I want to run away from. I think it's very important work, and I am glad many physicians in our state agree with that, so, yes, I would do both over again, yes.

EVA G. SIMMONS

Eva G. Simmons is a native of Summerville, Texas. She moved to Austin with her family in 1945, and completed grammar and high school there. She attended the University of Texas, Austin, and received a B.S. in Education in 1963. She received her M.Ed. from University of Nevada, Las Vegas, in 1975.

Mrs. Simmons moved to Las Vegas after graduation from UT, and worked as a social worker for one year before accepting a teaching position with the Clark County School District. In 1978 she moved into school administration, first as an elementary school principal, then as assistant personnel manager, and director of employee management relations. Since 1989 she has been the area superintendent for the Elementary Education Division in Clark County.

Mrs. Simmons has been active in community affairs, and has served on the Clark County Juvenile Probation Committee for fourteen years. She was a public member of the Nevada State Board of Medical Examiners for fourteen years, and is currently a trustee of the North Las Vegas, Civil Service Board.

Eva G. Simmons: I was born in a little town in south central Texas known as Summerville, Texas. Probably the closest town of any size is Houston. My sister is my only sibling.

Summerville, Texas, is a small, farming type of community. My dad was in the army, and my mother lived with my grandmother and grandfather. The role of the female at that time was to stay home and take care of the kids when they are little, so that's what she was doing.

I lived there until I was six years old. Upon the death of my father, my mother had to go to work. We moved to Austin, Texas, where she could find work. The money available through social security, I guess, was not adequate. Plus my mother felt that my sister and I would have a better opportunity in a larger town. My sister and I consequently attended elementary, junior high, high school, and college in Austin.

My mother did domestic work in private homes. She had a high school education, and opportunities, for black females in particular,

were very, very limited at the time. She had not worked before.

Anita Watson: You said your mother had a high school education. Given her experiences, did she emphasize education?

Oh, most definitely. My mother believed very firmly in education. I was greatly influenced throughout my life by my grandmother's sister, who was a school teacher. Then, after we moved to Austin, our neighbors were both teachers. My mother worked seven days a week, and my sister and I attended church with Mr. and Mrs. Lynch, who were our neighbors. They eventually became our godparents when we converted to Catholicism. They were also very influential in our decision to pursue a higher education and for me a career in education. My sister went into nursing. So all of those were influences in my life.

I attended the University of Texas, Austin, where I majored in health, physical education, recreation, and dance. I worked my way through college by working for the Austin Recreation Department teaching dance, stunts and tumbling, exercise classes, things of that nature. It's interesting that I've never once taught in those areas.

Was it a good job?

Yes, I thought so. I recall that my salary when I left that department was \$1.45 an hour, and that was a lot of money then. I was very proud that I was able to save money. That's what enabled me to pay for my tuition and my room and board. Now, I would have done that anyway, but the work that I probably would have been doing would not have been in a professional area. I probably would not have had flexibility of scheduling the classes that

are part of the Recreation Center around my college classes. So that was another blessing that accrued to me.

The director of the Recreation Center in the black community was a former neighbor of ours when I was a kid. That gave me an entree into seeking employment. Given the segregated environment, even in the Recreation Department, I'm sure that he was my mentor in acquiring that job for me.

Were you active in the Civil Rights movement during college?

Well, yes. We were at UT during the days of the sit-ins, and pray-ins, and kneel-ins, and all of that. My husband and I participated in the boycotting, and the picketing, and so on at UT. I was always scared to death that my mother would spot me on the TV and call and give me a lecture about, "What are you doing? You're going to get yourself killed!"

I remember the time at UT when the administration was particularly disgruntled with something that we had done. They summoned all 300 black students — this was in a school population of about 26,000 — to this big lecture hall. The dean was there, and the dean attempted to motivate us to tell who the leaders were, and to intimidate us not to do those kinds of things again. Among these 300 students there were undergraduate as well as graduate students. In those days, and even now to a great extent, a black graduate student was somewhat of a rarity. So you would look at these people in awe, and listen to what they would say. You kind of obey — you know, it's sort of like responding to your mother, your father, your grandma. We all stuck together, and so the university was not able to carry out those threats, because they would have had to suspend, or whatever you do to college students, all 300 of us. We were

very proud that we did stand together for what we thought was right.

UT is the kind of school that really does not like negative publicity. Southerners don't like it. Consequently, the area around the university was desegregated, the restaurants and the theaters, and all of that kind of thing. That was due partly to the efforts of the black students who were there then. I realize now that it was an event whose time had come, because the wave just kind of went across the country.

My mother was residing in Nevada then. In fact, my family moved here in the mid-1950s, after my sister married and moved here. My mother and I came to visit, and my sister had just had a little baby girl who was premature, weighing in at two and a half pounds. There was no way my mother was going to go away and leave that poor, pitiful little baby.

I went back home to college because in those days UNLV had night classes at old Las Vegas High School. That was not the college I had dreamed of. I really had the best of both worlds back in Austin. I lived on campus, I worked and managed my money, and went to school. But it was home, and my godparents were there. So that was kind of a neat experience.

Anyway, I did graduate from UT. I met my husband there, and we moved to Las Vegas in 1963.

Did you have a job here prior to the move to Las Vegas?

No, it was pressure from the family that prompted the move, because my mother and sister were living here. There were really only the three of us, because, as I said, my dad died when I was very young. They wanted the family to be united. It was OK with my

husband, so we came out for a visit to place applications, take tests, and to do all of that kind of thing. Then we returned "betting on the come," as we would say in Nevada.

My husband had two interviews. His first job here was as a porter in one of the hotels downtown, but that was the way it was then. Later on, through another acquaintance and another individual who was willing to risk, he became employed in his area of preparation, which was engineering. He is now senior project engineer with Raytheon Services. Nevada has been good to us in spite of obstacles that confronted us. And it's home now.

Was there a large black population here?

No, there was not a very large black population in west Las Vegas or in Las Vegas, although it was a growing population. With the advent of the dam there was a certain influx, especially from the southern states. I guess I could say that the black population in Las Vegas was not only relatively small, it was confined to that area. We didn't have choices about where to buy homes, regardless of the ability to do so. In 1965 or 1966, Sproul Homes built a subdevelopment in North Las Vegas, which is just north of Lake Mead Boulevard. The black people who continued to come were able to buy homes there and in other black communities.

The community was so small and so close-knit, and, of course, we patronized the professionals who resided in the community. Consequently, I knew Charles I. West, who was a family physician at the time, and James McMillan, who was the family dentist at the time. Their offices were convenient, and they were accessible.

Similarly, I knew the first black principal in the whole state, as well as the first black

female principal in the state. I recall when other black principals were appointed. These are people of my generation, and that was an inspiration for me, too. Their achievements prompted me to look behind beyond the assignment of the classroom teacher, to something more.

When I moved to Las Vegas in 1963, I worked the first year as a social worker. In those days, professionals were very much in demand here in Las Vegas, regardless of your preparation. It was a matter of passing the civil service exam. Plus, I suppose it was helpful that my college minor was sociology. I did pass that exam, and acquired a position as a social worker.

The background for that is a very interesting story. Our former governor, Mike O'Callaghan, at that time was the director of Nevada State Welfare. I had taken that exam, and I had received the little postcard in the mail indicating that I had passed the exam and that I should expect additional communication later. As I became acquainted with the members of my community here in Las Vegas, I talked with some other individuals who had taken the test. People who had passed, who had received the card, and who were expecting communication at a later date, which never came.

A neighbor of my sister's was a friend and associate of Mike O'Callaghan, and he mentioned this story to Mike. Mike perused the personnel records up in Carson City, and he observed all of these folders with the little red check marks on them. Of course, the red checks were on the folders of the black applicants. Mike being the kind of man that he was, pulled all of the red-checked folders.

As director of Nevada State Welfare he hired us — there were three of us — and we went to Carson City for the training and orientation. He picked us up at the airport,

and showed us around the city, and just really made a display of what his intent was regarding us. The three of us became employed in the office here. It was on Bonanza and Veterans Memorial Drive, I believe. That was my entree into employment here in the state of Nevada.

I really wanted to teach, however, and I had interviewed for a teaching position with the Clark County School District. Toward the end of that first year of employment with Nevada State Welfare, a teaching contract came in the mail, which I signed and sent back. I was really relieved that I didn't need to have another interview, because I was pregnant at the time. I knew what a problem that was for a female person seeking employment in a new arena.

Our daughter was born August 8, and I went to work as a teacher three weeks later. It was in a first grade, for which I had no preparation. But in those days if you were a black person, regardless of your preparation, if you were hired, you were assigned to the Westside schools, which were segregated with black kids. So then I had another challenge, and that was to become the best first grade teacher that I could become.

I recall complaining about the principal in the school where I was teaching. I guess I would describe him as a laissez-faire kind of a guy, and he certainly didn't conduct the business as I would have conducted similar business. My husband said to me, "I'm tired of hearing you complaining about your principal. If you think that you can do it so much better, why don't you go and get the master's degree, and do what you need to do to become principal?"

Well, I love a challenge, and so I went to UNLV, got the master's degree, and eventually became an elementary principal and went on from there.

The fact that you're black and a woman must have been obstacles.

Yes, I encountered a number of obstacles. But my attitude has always been, and still is, "It's only an obstacle; it's your perception of it." If you perceive it as a challenge, something that you just work at, work at, and if you believe you're going to do it, then you probably will.

We had lived here about nine or ten years, and we had two children. Our son and our daughter were both born then. My sister's four children are older than my two, and my mother had remarried. Between all of the family, it was just not a problem for my children to be cared for while I went to school evenings.

I do remember having the oven going, and three crockpots, and four burners on the stove. I'd cook up all this stuff so that I could race home and serve the dinner, and give instructions about the homework before the family person came to finish up. My husband was assigned to the Nevada test site at the time. He was on the bus at 6:00 in the morning, and he got home at 6:30 in the evening. Except for the encouragement that he would give, there was really no help in terms of managing the logistics. I'm grateful to my mother and my sister for their support.

How long did it take you to get your master's?

Two years. [laughter] Two years and two summers. I was fortunate in another sense, too. I was selected for a position as a Teacher Corps team leader. Teacher Corps was a federally funded project to prepare individuals with an undergraduate degree, in something other than education, to become teachers. That provided a quasi-administrative type of

experience for me. I think it was wonderful preparation for the principalship.

I worked with a team of interns and a group of teachers that were assigned to that team. It was a competency-based teacher education program. It gave me lots of exposure to the power structure in the district and at the university. And all of that exposure, and that opportunity to network, I think, has served me very well. You know, whatever you achieve, you didn't achieve it alone. My grandma used to talk about the bridges that bring you across. All of that opportunity, and all of those people, were bridges that assisted me along the way.

Were you politically active in the school district? Was that necessary to progress?

I would imagine most people in the district would describe me as being outspoken, opinionated. I was never labeled militant, and that's probably a miracle. I think my approach has always been to observe the appropriate protocol, and to acknowledge title and position in a way that's highly acceptable. So maybe I have been able to voice my opinions without it impacting on me in a negative fashion.

And my appearance is, and has always been, conservative and appropriate. I'm not into the corn rows, and I never liked the Afros. So my physical appearance was not as threatening perhaps as some were. I guess that was helpful, too.

But, yes, even now people in the district know that they're going to get a candid, honest opinion from me. If they don't want to know what I think, they should not ask. If I feel strongly enough about it, then I take the time to voice my opinion where I think it needs to be voiced. That's been tolerated, if not accepted.

I guess I would say, without appearing to brag or anything, that I have enjoyed a wonderful reputation as a principal administrator, and as one who is always available there for help. On the other hand, individuals also acknowledge that when there's some tough business to be taken care of, I do that, too. Then I move on the next thing. I guess that sort of describes Eva Simmons, the person.

What is your position in the district now?

I am area superintendent for the southwest area. I oversee twenty-five urban schools, and five rural schools. That's a really big job. I like it a lot. This is my thirty-first year in the district, but I'm not ready to give it up yet. I'm not stressed out; I'm not tired; I'm not frustrated. I love my work, and I think I still have something to contribute. I have lots of energy. So I'm still doing it.

Clark County, southern Nevada in general, has experienced a lot of growth and the attendant problems. I'm surprised you're not burned out or stressed out.

Well, I'm not sure why I'm not, unless I'm just one of those fortunate people that physically and emotionally I don't internalize. As I said earlier, my tendency would be to think of new ways to attack a problem rather than thinking, "Woe is me. Why is this happening? This is a problem." But I think attitude has something to do with that.

Prior to this assignment I worked in the Personnel Division for many years with recruitment and employee selection, and negotiations, and discipline, and affirmative action — and all of that. I think that my background and all of the experiences that I've had in the district make me especially

well suited to fulfill all of the roles that are necessary in this position.

How long has it been since you actually taught?

Oh, gosh, my first administrative position was in 1975, so I taught for ten years. I think of myself still as a teacher because I teach principals, so I'm still teaching.

How did you get involved with the Board of Medical Examiners?

I was appointed to the Board in 1980 by Governor Robert List, a Republican. I'm not sure how that happened yet, because I have always been a registered Democrat. I was reappointed by Governor Bryan, and then reappointed again by Governor Miller. Our superintendent at that time was Dr. Kenny Guinn, who is also a Republican. And I suspect that Governor List probably got my name from him.

Were you aware of the Board before you were appointed?

Not consciously. Dr. Maclean was on the Board at that time. Bryce Rhodes was the counsel for the Board, and Joan Rogers was secretary to the Board.

I thought the operation was peculiar at the time. [laughter] There was no real agenda. I remember the men walking around the room, smoking their cigarettes, and just kind of conducting the business in a loosey-goosey fashion. Joan took notes or whatever she did.

I've given it some thought since that time. Perhaps we were not obligated under the Open Meeting Law. When did the Open Meeting Law come into effect?

1977.

That's an interesting question. I never recall any public or any reporters being there. I don't recall discussing any infractions that a physician may have been accused of. I recall maybe one hearing. But the absence of structure was one of the things that really hit me. I remember being told that it wasn't necessary for me to return on a Saturday because that was the day the physicians were giving the examination.

Of course, I returned on Saturday. That event also struck me as being unorganized. I don't know how decisions were made. I don't even recall a vote, although I surely must have voted on something at some point. I just don't recall it.

My first real impression of the Board came when Dr. Jacobs was president. We went in the routine of putting in some protocols, and getting something organized. One of the first big events was when we made the decision to revise our law. A consultant was hired to come in and give us advice, develop a proposal, and so on.

That was really an exciting time, as a public member. To be a part of developing, of revising the Medical Practice Act for the state of Nevada — a law that would be in place until modified — was just really exciting for me.

Was there a lot of discussion?

Oh, yes, there was a lot of discussion, point by point, the pros and cons of this language versus that language. The consultant was very knowledgeable and was able to share with us the trends. He was able to talk with us about why we should consider "A" rather than "B." His emphasis was really giving the greatest latitude, I think, to the Board, so that we would have a real opportunity to respond in a way that would protect the public interest.

And, you know, our Medical Practice Act is a model act now. Many states are just beginning to try and accomplish the things that we had the foresight to do back then. Somehow we felt that we had a really good chance of making those massive changes in the 1985 legislature, I believe it was.

What prompted the revision? Was there anything specific?

I don't recall anything precipitous. What I recall in general is that as we discussed issues relating to allegations against physicians. We felt so very limited in terms of what the pre-1985 law was, and, consequently, we wanted a greater, broader opportunity to respond. My memory is that that is what caused us to seek the revisions.

And what a wonderful investment it was. I believe we paid the consultant something like \$10,000.00. I remember once that we became very anxious because we thought the cash flow was going to be a problem. I think we tightened up on some other areas so that we could get this one finished. And we did. Of course, with the passing of the new law, it gave us an opportunity to increase fees so the Board could be appropriately staffed, and that has made a big difference, too.

It's obvious the level of professionalism has increased.

Is it to you?

It really is. Particularly when you look back at the minutes of the 1940s and 1950s, for example. They're talking about purchasing file cabinets. There is a progression from two or three pages of minutes to twenty-four or twenty-five pages, and from often trivial details to more important matters. One of the notable changes is that the disciplinary

process is more formal. There also appear to be more challenges, on the part of the physicians themselves, to sanctions imposed by the Board.

Yes. Physicians, like every other citizen, have a right to due process. I guess my belief would be that the law “has to gel.” The law gels through legal challenges to the language of that law, or the application of that language to a given situation. I see it as being similar to the negotiation process where you work with an adversary to come up with some common language. Yet the tone of that language is really determined through the process of grievances, of arbitration. I see the law increasing in its parity as the result of legal challenges, so all of the challenges don’t bother me. I see that as part of the process, and part of what is necessary.

Certainly doctors recognize that their license is their livelihood. The Board recognizes that, too. I think the Board accepts its responsibility to take the steps necessary to protect the public, but not to take steps beyond that. I think that the general public has no grasp of that concept.

Do you think there might be a certain amount of distrust on the part of the public with physicians “healing” themselves? That physicians who oversee their fellow physicians will overlook and forgive?

I’m sure there is a great deal of distrust. I think the general public is just pissed off with government. A large segment of the general public is upset with anything that they perceive as bureaucracy and government. The Medical Board would not be perceived any differently than that.

The other part of that would be that group of people who feel that physicians belong to

the club known as “physicians.” Their job is to protect members of the club. Therefore, physician members of the Medical Board would not be predisposed to correct, but rather to shield and to protect.

I don’t think our Board is that way at all. I think our Board collectively — I’m talking about as it was constituted when I was a member of the Board — is very analytical. And they should be. That’s part of the skill that a doctor has.

They were always very open to the point of view of non-physician members, of public members. They were always careful to ask for an opinion from the public perspective as a public member saw it. That demonstrates to me a special sensitivity to the general public on the part of the Board. And I think that’s mighty special — I really do.

As a public member, what did you perceive your role to be?

I guess I always saw my role as a public member to be one of looking at issues from the public member’s perspective. I remember once asking a question when we were placing some contingencies on a physician to have a monitor or another observer or consultant, whatever they call it, when they were doing a certain procedure. I said, “Well, now, who’s going to pay for that?”

“Well, the patient, of course.”

“Oh, no, it’s not the patient’s fault that this other person has to be there to oversee. That should be at no cost to the patient.” And, from that point on anyway, the doctors discussed it, and the language then always became “at no cost to the patient.” I think that was fair. The initial response of “well, the patient . . .,” I think that’s because traditionally, when you have a back-up physician during a surgical procedure, that was always a cost for the

patient. They just voiced what was traditional, and maybe at that one point didn't stop to think about the impact on these other people who are paying. They have been reasonable in terms of things like that. And that is but one example.

Did you find that it was difficult, as a lay person, to censure physicians?

No, that was never a problem for me. Perhaps that's because, having worked in public employment all of my life, I know that there's a certain behavior that's expected. There's an ethical base to the work that I do and how I approach it. It's easy for me to assume and accept that that's true for others as well. And it's equally as easy for me to say when there's a breach in that, then you should expect to pay some price. So, no, it was never difficult. For some reason, I became the one who would most often make the motions for these kinds of things. I wonder who's making them now? [laughter] But, no, that was not hard for me at all.

Physicians would sometimes bring members of their family to the public hearings regarding their fate. I was not especially moved by that either. I focused on what I believed about the testimony that I would hear. That would be what I would use for my decision-making when we went into deliberations.

During your tenure on the Board, there was discussion of combining the Board of Homeopathic Medicine with the regular practitioners. The Board's response was to reject that proposal because there were basic ideological differences. Did you see those differences, and was your perception of different approaches to medicine affected by your time on the Board?

Yes. I have one girlfriend whose physician was a homeopath, so I became familiar with what those beliefs were through the eyes of a friend. I didn't buy the philosophy as she explained it to me. When there was discussion on the Board about combining, it was easy for me to conclude that would not be appropriate. Water and oil don't mix.

While you were on the Board, there was a change in the examination process. Compared to earlier years, it became much more formalized.

After the legislature approved the 1985 Medical Practice Act, we were then able to look at various other issues, issue by issue. Examining physicians in an objective, equitable manner became one of the issues that we looked at and talked about, year after year after year after year. It did evolve from asking physicians questions off the cuff. We used to have a public member read a statement — and I used to know it — where the physician had to attest to all of the entries on the application being true and accurate to the best of their knowledge and belief.

As of this year, I guess, we discontinued the face-to-face oral examination. Prior to that time, we had always felt that we wanted to eyeball the physician because you might pick up on something by face-to-face observation of a person. Tom Scully is excellent at keeping statistics, and looking at those, and walking us through instances that implied action from those tables of data. What we concluded was, with a physician that may have some difficulty, there is some evidence of it in all of that information that we verify.

We also came to realize, with the advent of the national data bank, which included information which has already been verified and so on, that it was not good use of our resources to do that same thing again. There

were various standards and sources that were coming into place from a national level that were useful to us as a state board. I think we have modified our behavior according to those.

Dr. Scully, of course, worked on the national medical board committee to develop the exam for physicians with the minimum competency exam. Once that was completed and validated, I was proud that our physician members were willing to take that risk, and took that exam. They all passed, by the way.

Those exams further modified what we do, and how we approach physicians. When we changed the law in 1985 to require three years of postgraduate study — many physicians were moving here with only two years — we had a new way for them to demonstrate minimum competence. All of those things have come into play to cause us to modify the way we do things. Time is money to a physician, to me, too, to all of us.

We were meeting four times a year, I think, spending three days on Board business. One of those days was devoted to conducting face-to-face interviews. Now that they don't have to do those things, that energy can be spent working on some other issues or tasks that need to receive attention.

My impression is the three days that you actually met was just the tip of the iceberg; that there was a great deal of time in preparation.

Oh, absolutely! The staff worked like little Trojans to get ready for those three days. For the Board members, yes, there was a lot of preparation for the meeting. That is very true. One of the big advantages to the new law was the ability to have a hearing officer to establish a record. It was really horrendous for the Board members to sit there, and hear all the testimony, and keep all of the notes. Then, to

try to summarize all that in some way, so it was useful whenever you got to deliberations and all? I think the system is much better now.

Were you on the Investigative Committee?

Only for about a period of, maybe, six months. Most of my time was spent on the Internal Affairs Committee. When we started to add additional staff to implement the new requirements and so on, we established a personnel committee, I believe it was. That placed me in a position to really provide a very unique service for the Board, because I had many, many years of background in personnel. And not just the background, but the contacts that I had to do networking, to consult about what the Board needed to do.

At some point, they made the decision to change the personnel committee to the Internal Affairs Committee. But during the course of that, we'd established policies and rules and regulations. We really changed part of the role of the administrative staff of the Board. We even developed the performance appraisal documents. We would review the documentation and make recommendations to the full Board about what actions to take.

That was useful at the time. The Board is well-organized; it's stable. The support staff now assumes a variety of task-staff evaluation, budget preparation, etc.

The Board members don't need to do that work anymore because the administrative and professional staff are able to fulfill those functions. Then it's just a matter of the Board acting on staff recommendations.

One of the things that seems to have become a big issue in the period that you were on the Board, and over the period of formalization, was intervention for substance abuse. How did you perceive that action while you were on the

Board? Did you see it as an effective way of dealing with physicians?

In recent years, yes. The Board provided some funding to the medical societies, one up north and one down south, to take on that responsibility of providing assistance to physicians with substance abuse problems.

If I recall correctly, the question on the Medical Board itself was, "Is it our function to fund this kind of thing with the medical societies?" I think what we concluded was that it may not have been our function, but it certainly was a need that should be fulfilled, that it was necessary to protect the health and safety of the public. Consequently, we did provide money so that could occur.

As I recall the last update on that, things were going very well. That's been another payoff for the citizens of the state of Nevada. We operate on the fees that physicians pay. If a service can be provided that is in the best interest of the public in some other arena that's related to what our mission is, I don't have a problem with that. I think that's appropriate, in fact.

Did working with the physicians on the Board, and those being disciplined or examined, affect your view of physicians in any way?

Yes, it really did. You know, there are some professional people that we hold in a special regard: teachers and preachers and physicians. Some of what I came to know about the behavior, or lack of appropriate behavior, among physicians was just appalling to me. Absolutely unbelievable. Prior to my service on the Board, I had no conscious thought that physicians are human, too. They make mistakes, and they do stupid things, and they do illegal things, and they do naughty things. I never thought about that. That was something I had to come to grips with. Sort

of like coming to grips with these priests that have been found guilty of doing things that are illegal and highly inappropriate. It's somewhat devastating at first.

And it's in the best interest of physician members of the Board to do what is right when they have infractions. That is the most significant step to take to maintain that level of status for all physicians.

Regarding your tenure on the Board, what was the best of it? What was the worst of it?

What was the best? Two things. That was a very stimulating environment for me. It was different from my work routine, and, yet, the knowledge gained in my work was useful to my role on the Board. So that was a nice match. The other thing is the friendships that were made through that long association on the Board.

What was the worst? [pause] Probably the worst moment — and that's even true in the work that I do now, although I'm able to do it and do it well and with success — is terminating employees. As vice-president of the Board, responsible for personnel and internal affairs, a lot of that fell to me. And that's never an easy thing. It's just a necessary thing to do sometimes. Those were probably the worst times.

I enjoyed the national meetings for the Medical Board. I probably went to three, maybe four of them. The sessions were really interesting and informative, and I always think physicians really know how to live — they don't need all day. They always saved some time for relaxation. Not that there was wasted time at dinner. We were still talking about issues and whatever. But those were nice times, too.

It was nice that when I concluded my tenure on the Board, I received a letter from

the governor. That's probably typical. I also received a very nice certificate acknowledging our service, and I received a call from one of the people who works for the governor, sharing with me the nice things that had been said. I assume they were said by other Board members. They asked me to let them know if there were ever another board that I wanted to serve on. I kind of threw it back at them, saying, "Well if there's ever a board where you think I can make a contribution, let me know." You know, I'm not going to go running around looking for a board to serve on, but I rarely say no if I am asked to do something.

DELMAR SNIDER, M.D.

Dr. Delmar Snider is a native of Oakland, California, born in 1934. He attended the University of Notre Dame for a year, then accepted an appointment to the United States Naval Academy, where he received a B.S. in Engineering in 1957. He was commissioned a lieutenant in the United States Air Force in 1957 and received his master's degree in Electrical Engineering from the University of Illinois in 1958.

He resigned his military commission in 1962 and went to medical school at the University of California, San Francisco. He received his M.D. in 1967, served his internship at St. Mary's Hospital, San Francisco, and his residency in anesthesiology at Stanford University. He taught at Stanford after residency, then entered private practice. He relocated his anesthesiology practice to Carson City, Nevada, in 1974.

Dr. Snider has been involved in business outside his medical practice in medical electronics, as well as working on the application of computer technology to anesthesia. He is a licensed private pilot and owned an aviation service in Nevada from 1979 to 1985.

Active in medical politics, Dr. Snider has served as president of the Nevada State Medical Association, been a trustee on the Board of Carson-Tahoe Hospital, and a member of the University of Nevada School of Medicine Admissions Committee. He was appointed to the Board of Medical Examiners in 1987 and remained active until 1992.

Delmar Snider, M.D.: I was born in Oakland, California, before they had a professional sports center, and nobody knew what or where Oakland was. I went to grammar school there and to St. Joseph's High School in Alameda, a boys' Catholic high school. My graduating class numbered thirty, so you can tell it was a small school.

I had a brother who was three years younger than I, and a sister who is eleven years younger than I. My brother was killed in an auto accident at age twenty-two. My father started life, as I remember it, working in a stock and bond office, and one of his memorabilia is a ticker tape of the day the crash occurred, starting the stock market fall

that led to the Great Depression. He went through a variety of other jobs and ended up finally as a fireman in the Oakland Fire Department. He was a heavy smoker and succumbed to cancer of the bladder because of that at age fifty-three.

My mother was born in the Twin Cities, one of nine children. She lived in Canada in her pre-teen years and then moved to Oakland. French was spoken in her home, although she never learned it. She was the first member of her family who graduated from high school. She became a comptometer operator. She had an interesting career, and she always stopped working when there were little kids in the house.

She played the piano very well, and my father played the saxophone and clarinet. As a youngster I ended up taking piano lessons instead of baseball lessons. Today I enjoy a magnificent grand piano that I just got two weeks ago. At least I can enjoy this any time, no matter what the weather is like or how much sunshine there is. [laughter]

My sister was so much younger than I that I really didn't know her much more than just being a little pest around the house. By the time I went away to college she was only seven years old. Her memories of me are not real favorable because all she remembers is every time I came home from school, everybody had to get the house cleaned and put on their best manners and all that kind of stuff. She reminds me of that from time to time. She lives in Quebec; she married a Frenchman, so all her children are bilingual, although the youngest two are much better in French than they are English.

Anita Watson: You said your mother was the first in her family of nine children to graduate from high school. Did she emphasize education?

Because of the fact that her uncle was a priest at Notre Dame, from the time I was old enough to understand, I was going to Notre Dame. I can remember as a little kid I had a catalogue from Notre Dame on a bookshelf on the wall. Aside from distant relatives who were in the priesthood, I was the first member of my extended family, which numbers well over one hundred and fifty people at this point, to go to college.

You didn't rebel against the plans for Notre Dame?

I was a fairly docile kid. I matured late; I was always a little boy relative to my peers. It was just a matter of certain goals being set for me by my parents. I accepted those and made them mine.

Unfortunately I didn't have anyone I could talk to in my family who could advise me about college. When I went to Notre Dame, I was a physics major; I didn't even know what physics was about; it just sounded attractive to me. While I did fairly well in an academic prep high school, I was totally unprepared for what I ran into in physics at Notre Dame. I was now amongst extremely brilliant people in my class and needed calculus to study physics. We were taught differential and integral calculus in three weeks. Normally that is two semesters worth of course work. I didn't quite make it. I struggled through that first semester. At the end of the semester the professor in physics told me that he would give me passing grade, which is a D, if I would get out of the college of science. [laughter] I might add that I paid my own way to college because my parents could not afford it. I started working at the age of nine, when I got my Social Security number, and I had saved over two thousand dollars. It was going down the drain fast at Notre Dame.

One of the things I observed in high school is that the future successes were going to be dependent on skill in taking tests because we were getting tested for all kinds of things. I made the decision that I would start taking tests, any kind of test. In my senior year in high school I was taking just about every test that came up that I could make it to. I went all over the Bay area, usually to government buildings, to take these tests.

To hone your skills?

Yes, just taking the tests to take the tests, with the point of, first of all, to get over written test anxiety. Secondly, to get used to reading the questions and quickly ascertain what the question is and what kind of an answer is required, then looking at the various choices and understanding the testing mechanism. There really is a skill to that.

Coincidentally, I had taken an examination for appointment to one of the service academies. I just took the test because it was another opportunity to take a test. On the check-off list on the first page of the test was which service academy you want to go to — the army, navy or coast guard? I wasn't interested in the coast guard, and the army didn't appeal to me, so I checked navy. This test was being offered by a congressman as a way of selecting those that he would appoint to the various academies.

I finished my job that summer and went on to Notre Dame, and, as I was telling you, I was not doing well in physics, so I switched to electrical engineering in my second semester. We got into engineering math. I don't know whether it was chemistry or something, but there were two courses that were giving me great difficulty, and one was the math course. I was being devastated by this because I could

see my college career coming to an end on two counts, academics and money. In the fall of that year I had gotten a letter from the congressman saying that I had won an appointment to the Naval Academy. I had absolutely no interest in the Naval Academy; it was merely an exam that I took. I threw the letter in the drawer. Then in the middle of my second semester when I saw that I was still having difficulties, that Naval Academy thing — well . . . I found the letter with three days left to respond. Respond I did, and sent them all the information that they needed. My history grades were so poor in high school, they would not credit me with a high school graduation. With one year of college, however, you would have to take no exams whatsoever; just pass the physical. I had to take a full range of exams, and thank God I had the experience that I had. They grade on a 4.0 basis, 4.0 being a hundred, and zero being zero; 2.5 is passing, and I got 2.5 on the history exam. Had I missed one more question I would not have passed the exam.

On the physical exam, as I mentioned, I was still a kid when I was in high school; I didn't start shaving until I was in college. I grew six inches after I got out of high school, and I was still going through all that stuff. As a little kid in high school, obviously I wasn't involved in athletics the way the more mature guys were. I almost flunked the physical exam for the Academy, but I got by with a minimum score there as well, and was accepted in the Naval Academy. I left Notre Dame at the end of my second semester in early June, went to the Naval Academy on June 23rd, and started in as a plebe. And life was never the same. [laughs]

I did fine. I was average; didn't get in any trouble more or less than anybody else, and didn't have any unusual difficulties. In my

first two years I was, oh, sort of academically somewhere around the middle third of the class, at the lower end of that group. I almost flunked out with German.

Then in my last two years we got the science and engineering. I excelled. As a teenager I was a ham radio operator, so I was very much into electronics and had a lot of experience with circuits. When I took electronics at the Naval Academy, I didn't have to calculate the answers; I knew what they were because I was just experienced. I had such a jump on it. We started with twelve hundred and fifty guys in our class and graduated eight hundred and eighty. In those last two years I was like seventh in the class in electronics; first for a while, but I ended up seventh. I came within a couple of hundredths of a grade point of graduating with honors. It was a real sort of a switch.

During this period that you were at the Naval Academy, from 1953 to 1957, weren't electronics changing a great deal? Wasn't the transistor coming into use in the 1950s, or am I off on the time?

No, you're pretty close. In our text books everything we did in electronics was with vacuum tube circuits, with probably several paragraphs with reference to transistors as a new device that was coming out. But everything at that point still was all in vacuum tubes. We also had a sort of a brief introduction to computers, which sparked a real interest for me.

As I was nearing the end of my Naval Academy career, we First Classmen were subjected to many career guidance lectures. Watching all those navy captains stand up in front of us, saying they'd been in the navy thirty years, and they had spent twenty-eight years at sea and loved every minute of it — I

started having second thoughts about the navy. I loved the sea; I enjoyed it thoroughly. My summer cruises were terrific experiences. There's a peace and tranquility about the ocean that is matched by few other things. But I really didn't want to spend that much time away from home.

At that time the academies had a policy that up to 25 percent of the graduates could go to other services. The Air Force Academy, although it had started, did not graduate its first class until 1959. So there were no Air Force Academy graduates in existence at the time I graduated from Navy. I elected to take my commission in the air force. I had asked to go to graduate school, but they denied it, and I was all set to go to Biloxi, Mississippi, to become a communications officer. At the last minute our air force rep at the academy called me into his office and said, "Do you still want to go to grad school?"

I said, "Yes."

He said, "Well, there's an opening at the University of Illinois."

I said, "I'll take it." [laughter] So my first tour of duty in the air force as was a year of grad school at Illinois, Urbana campus, where I got my master's degree in electrical engineering, with my major being computer design. It was the last time they taught the course in vacuum tubes. The next year it was transistors.

This is the time then when the computers were the size of a house, or were they coming down a bit?

The smallest commercial computer facilities were getting into the range of the size of a basketball court. There was the ILIAC computer at Illinois that occupied, oh, maybe a thousand square feet, but in commercial activities they were huge.

In my next four years as a computer systems engineer in the air force I worked in research and development at the Intelligence Data Processing Laboratory in Griffiss Air Force Base in Rome, New York. That was an interesting job. It was very, very secure; you had to go through two levels of security to even get into the building. All the papers that you worked with every day were locked in the safe. I could not travel outside the United States. It was just really a different kind of world for me.

There was myself and one other lieutenant with formal training in computers. We were consultants to the air force, and here I am twenty-three, twenty-four years old, a youngster by any standards. I was travelling all over the country, and my peers were twenty years older than I. I was briefing generals and colonels in the Pentagon and traveling to research labs all over the country. It was a lot of responsibility for a very young man, and it was an awesome experience that could not have been gained any place except in the service.

It changed my viewpoint of age as a criteria for anything; it just didn't mean anything anymore. People were who they were and what they were, and how old they were didn't really make any difference. I really haven't thought about it in those terms I guess except for this moment, right now.

What exactly was electronic intelligence? You mentioned that security was high. Were they setting up networks? What was going on?

Well, electronic intelligence is an intelligence that is usually gathered by some sort of vehicle, like the B58 Hustler. That's a very, very high altitude, high speed bomber that could fly across Russia faster than anything could catch it. As a for instance, it would have

to get up in the air and get refueled and then fly like a bat out of Hell going across Russia, and land in Japan or Alaska or whatever, and get refueled there, and then get refueled in the air. It carried a pod underneath it that looked like a gasoline tank or a bomb with antennas down the side. It was full of electronics. What it did was gather information about Russian radar communications, any information that could be used to figure out what their radars did. Then counterintelligence could be developed so that when the B52 bombers were flying, they could effectively disable the Russian radars electronically. So that was what electronic intelligence was about — it was gathering information about electronic devices by the signals being put out.

This was the height of the Cold War?

Yes, and it was a very difficult time for the military, because as far as I was concerned, we were at war. We had to treat what we were doing that way. Everybody was totally dedicated. The pilots that flew the B52s — they were under a great deal of strain. They would get up in the morning, fly their missions, and be back that evening. Many times they would get up in the morning, fly their missions, and then call their wife from Africa or somewhere, and say, "I'm going to be here for three weeks." They missed their kid's graduation, first communion, bar mitzvah, or whatever. It was really very, very difficult for the air crews.

The civilian population at that time didn't seem to be taking this seriously, and for us it was very, very serious. I had a hard time reconciling what I was experiencing with what we were seeing in the civilian press and with what President Kennedy was doing. He was not a popular person with many in the military.

Reference has been made to the fact that the United States and Europe were living in the shadow of a mushroom cloud.

That's right!

Is that the way you felt?

I don't think I was concerned about atomic warfare per se, because I believed that what we were doing was preventing it, that we were being successful at what we were doing. It's just that the ongoing activities that we had, maintaining the strong military posture, meant that we would not have atomic warfare simply because it would lead to global destruction and there would be no winner. We had to be able to do what it took to respond to anything, and by being able to do that, then nobody would challenge us.

You mentioned that Kennedy wasn't popular.

Well, I had that conversation just the last week or two with somebody about this. I don't remember the specifics because I wasn't personally involved in a lot of this, but it had to do with family and military in foreign bases, Europe, the Mediterranean, Far East, wherever. And what he was doing in terms of cutting back on families to be together. The details are very, very fuzzy to me; it's been too long. I personally was not affected by a lot of this. But he was not viewed as a friend of the military.

You did this consulting, traveling around, development, research, for how long?

I did that for four years. I got married, oh, in February 1958, a little over six months after I graduated from the Academy. She was a nurse, and we had been married not quite a

year when I came home and found her in tears one day. I said, "What's the matter?"

And she said, "I'm going to die!" It turned out she was pregnant, and she had a strep throat several weeks before; I don't know how long. As a result of the strep throat, she now had an auto immune disease that was going to destroy her kidneys, glomerulonephritis. Kidney transplants were really not available at that time. So I basically, over the course of a year, watched her die.

What about the pregnancy?

She delivered a child. It was a month premature, a boy, and he only lived four days. He died of what was called hyaline membrane disease. It was interesting that the priest that was at the base there and conducted the funeral services for the child was the same one that was involved with the Kennedys when they lost their child from the same disease.

At any rate, during the course of her illness I spent a lot of time reading her books trying to understand what the physicians were telling me about the course of her illness. After she died, which was in December of 1959 — that was a bad year for me. In March of 1959 I got a phone call that my brother was in an automobile accident, and while I was flying home to join the family, my uncle died. I found out about that when I landed. A few days later I went to my uncle's funeral, and then within the week my brother died without ever regaining consciousness from the auto accident. I went to his funeral; three months later I buried my son; six months later I buried my wife. It was not a good year.

I decided I wanted to go into medicine at that point. I was also interested in being an astronaut. I didn't realize at that point I was about six inches too tall for it. It is relevant

only in that I went into that thinking what would be the best specialty for an astronaut to have, as an engineer. And anesthesiology, said this friend of mine, is basically life support. I thought that would be probably of some importance. So that's what prompted my first thoughts about anesthesia as a career.

I applied to medical school only in California. I had enough of the East and Midwest, and at that point I wanted to come back to the West. While this was going on my father died, and he never found out that I got accepted to medical school.

Was the family supportive of your making a career switch like that?

All except for one, my mother's younger brother, who worked at the Mare Island Naval Ship Yard and had a lifelong career with the navy. Having worked with the navy all his life and having seen Academy graduates and where they went, he thought I was crazy to throw away my Academy background in the military and go into some other field. I tried to get a leave of absence from the air force to go medical school; they wouldn't let me do such a thing. In later years they did, with others who requested that.

I applied to every medical school in California and was accepted by all of them except Stanford. I got out of the air force and went to U.C. San Francisco. By that time I had remarried; my new son was a year old, and my daughter was born six days after I started medical school. So we had a one-year-old and a brand-new baby. It was an economic struggle to go through school but I had the GI Bill, fortunately. I think it provided a hundred and sixty dollars a month.

Could you live in San Francisco on a hundred and sixty dollars a month at that time?

No. [laughter] It was a little over a hundred dollars a week minimum to live; somewhere around four hundred and fifty bucks a month was what I needed to exist. I borrowed heavily and worked when I was able, and had summer jobs. My wife worked part time.

Medical school was just a disaster for me. I was used to engineering books, where you had a little, thin book, and you covered a third of the book in a semester, and studied three or four equations and how to use them. I went to medical school and had two books the size of a Chicago phone book and was told, "Memorize them." That to me was what medicine was all about, memorizing. They say the average college graduate has a vocabulary of twelve to fifteen thousand words, or something like that. But they say the freshman medical student doubles this vocabulary. You have to learn to speak a new language, a language of medicine.

I remember my second year I wasn't doing well; I was passing my courses, but I wasn't doing well. At the end of the second semester the dean of students called me up and said, "Well, the committee on academic promotions has recommended that you go back to engineering and forget about medicine."

I said, "Well, Dean, how about if I repeat the year?"

He said, "Well, you need to give that some thought."

I said, "Hey, we both have been talking about this for six months." [laughter] It was an ongoing dialogue with every student; the dean stayed very much on top of what they were doing.

So he said, "Well, call me back in two weeks." Which I did and he said, "OK. If you want to do it, we'll let you do it." So I repeated the second year, did slightly better. You'd have thought I had would have done a whole lot

better, having been through all the material once before.

But it was still as onerous the second time through as it was the first time through. I hated it. It just was not my cup of tea. It was a totally different kind of learning. Then the third and four years were the clinical work, dealing with patients, and there I just did fine.

Why did you keep at it if you hated it?

Well, it was a goal, and the goal was to get through the program. I wasn't confusing the academics with the job of being a physician. There was a certain knowledge base you had to have, but I also knew no doctor out there practicing was into the details and the intimacies of biochemistry. I mean, you had to have the general broad knowledge and understanding of what the processes were, but there is no physician who has been out of school five years who can take and pass the biochemistry course unless he's working or teaching it. But then there were two things: the process was aimed at making sure that those that can persist, make it through. And that you do make it through with a certain minimum level of knowledge.

As you well know, as you continue in your education, the population that you are competing against becomes a smaller and smaller group of the people that are at the top. In other words, if you are ninety-ninth out of a hundred, you are still ten thousand times better than the guy that didn't go to college at all. So what you are looking at is a very select group of people. I was doing poorly relative to that select group of people I was with. There were five of us that repeated that second year, by the way, out of one hundred and five students.

In the clinical years, once I got into that, it all started to really click and I did well,

and I ended graduating in the middle of my class, having been at the absolute bottom. My grades in my last two years offset a lot of those lower grades in the first two years. Anyway, I did fine, and I felt comfortable at that point, and I felt good about what I was doing. I felt I had the skills, the temperament, the knowledge base to do what I needed to do.

You were still focused on anesthesiology?

When you go through medical school, every time you take a different rotation, you think: "Pediatrics, God, that was wonderful; obstetrics, that's great; neurology, that's terrific; neurosurgery, that's wonderful; general surgery, oh, that's great; and general medicine, oh, that's what I want!" But yes, I kept coming back to anesthesia. I had an elective my senior year, and I did take a six-week rotation in anesthesia. It just reconfirmed what I wanted to do.

I had to work during the summers and part of the year with one of the anesthesiologists who was doing some research in electro-anesthesia. I met a guy there who was building equipment, and he and I have had a life long relationship since then. His name was Bob Dempsey, and we talked about forming a company. He did, and I eventually became vice president of that company.

Anyway, when I graduated from medical school, I interned at St. Mary's Hospital in San Francisco. That situation was unique in that it did not have strong residency programs. There were one or two residents in surgery, one or two in medicine, and one or two in obstetrics, and we had a dozen or fourteen interns. Because we didn't have this hierarchy above us, and it was all private practice in that hospital, since it wasn't a county hospital, when something needed to be done that could be done by the house staff, we did it. It wasn't

the senior resident who did it; we did it. I think I had an excellent, excellent internship because of that. I learned a lot of medicine during my internship.

When it came time for residencies I applied only at U.C. San Francisco because that's where my mentor was, the fellow that I had worked for, and I knew everybody in the department. I don't know, because I was never apprised of it, but I think the fact that I had so much difficulty in medical school caused them to make the decision not to accept me into their residency. I had applied to no other residencies, and I was just devastated not knowing what to do. I started calling around. Stanford did have an opening that they didn't fill, so I went down and interviewed with them, and they offered me a position and I took it. In the meantime my mentor, who was gone during the selection of residents, came back, and I guess he raised a fuss. So in time U.C. San Francisco offered me a residency. I was a little upset, and I said, "Well — no."

I stayed at Stanford and I did fine. As I say, my internship I think prepared me very, very well for what I did, and I did very well in my residency. At that time anesthesia was a two-year residency; I opted for a third year to do research in computer applications to anesthesia. There was a big research project going on there. There weren't many people at that time across the country taking three-year residencies in anesthesia, so I was unusual in that I had that.

My senior year as a resident I was an acting instructor and also was made chief resident; there was just one. I was chief resident throughout my senior year. I was offered an appointment as an assistant professor at the end of that time. I told the chairman of the department that I wanted to go out and practice for a while, because my

best instructors, my best teachers were people who had been in practice and then came back to the academics. I wanted at least to have a couple of months, which I did.

I worked at two different hospitals on my own. My first night on call on my own, I was at Redwood City, Sequoia Hospital. A girl had fallen off of her horse earlier in the day, and this was around midnight. It was change of shift, and the new nurses coming on recognized something that the nurses on the earlier shift failed to notice: that this gal was deteriorating neurologically very rapidly. So my first case on call in private practice was a neurological case, and neurosurgeons are notorious. I was about to wet my pants, but I went in and saw the patient, went over the chart and got everything ready. I got the operating room set up for what I needed, and the surgeon came in. It was a guy I had worked with for the past three years, and it was his first night on call in private practice as a neurosurgeon. [laughter] We hugged each other and said, "Come on, let's do it!" [laughter] So we took care of that and it was fine.

While I was a resident I divorced my wife, and some interesting things happened with my kids at that point. She became a Mormon because the Mormon Church supports families a lot, and she would get that support. As a result of the divorce, I had to give her alimony and child support, and there was no support for me left over. In my last year of residency I had bought an upright piano because I was interested and thought I would explore. I had it about a year and I liked it, so I saved my money and bought a grand piano. When the divorce was over, I had my car and my piano and my books and the clothes on my back, and that was it. Financially it was very, very difficult for me when I was a resident.

You did some research on computers and anesthesia. That was an early period for it, wasn't it? Did you help in the development?

Well, at that time we were still using big computers. One of our operating rooms at Stanford was wired for all kinds of things; we could measure twenty-three different parameters. Unfortunately we didn't have the processing capability that I have in my own office right now because of what's changed over the years. For instance, I would be doing a case in a room, with the patient with all these monitors on, and three days later somebody would come up to me and say, "Well, you know during this part of the case the patient's oxygen got pretty low." It was only after they went through the tapes and were able to look at things and go through the computer analysis that they were able to tell me three days later what had happened. Well, obviously the object of this was to be able to speed this up to real time eventually so that you could use technicians in the operating room and have anesthesiologists monitor what was going on in numerous rooms. This would decrease the cost of the delivery of the service, as well as require fewer human resources in terms of training.

Did the project ever come to fruition?

No, I don't know where the project went because it was a long-time project, and, no, there's no such thing right now, although we certainly have the capability these days to do that kind of stuff. I don't know where the project ended up.

Some of the machines that they use are so incredible — the information that you can get. Was there more human contact, more judgement calls when you first started versus now with expanded technology?

Well, when I first started, the number one monitor was the tip of your index finger. You put your hand on the patient's head that is there in front of you, and you put your finger on the temporal pulse right in front of the ear. What it did is give you the pulse rate; it also gave you some measure of pulse intensity, which is the pulse pressure. And some sense of blood pressure. It also told you whether the patient was warm or cold; whether the patient was dry or sweating; whether the patient was still or moving. A lot of information came out of that finger tip.

We didn't have mechanical ventilators in large supply then; when I was in practice later on I had my own. But out of a suite of about twelve operating rooms there were only two other ventilators in the entire place. So we squeezed the bag. When you squeeze the bag, you can feel how much pressure it takes. You can also feel how quickly the patient breathes back in the bag; how quickly they exhale. You use these kinds of things to assess what's going on with the patient.

Actually you don't pay any attention to it. It's like driving a car: you're sort of on automatic until something happens, and then you're alerted to that; until somebody slams on their brakes in front of you. Otherwise, you drive home and don't remember any of the driving because your mind is paying attention to other things. But on a subconscious level you are very, very tuned to what's happening, and that was the skill of being an anesthesiologist.

By the time I got into residency, we did have electro-cardiographic monitors, electric monitors. But when I was a medical student, we had very, very few of those in the hospital. They were old devices with long tubes about two-and-a-half or three feet long and about four or five inches in diameter with a little three-inch television tube on it; just enough for you to see one pulse. It was just the very,

very early beginnings of it. The monitors when I was a resident were starting to improve slightly, and by the time I went into practice and purchased my own I had very, very sophisticated equipment available to me relative to what was going on at the time.

Now with the equipment that I have today and the knowledge that I have today about what's going on with the patient, we can do so much more for the treatment of the patients. We can do more exotic things in the operating room. The anesthesiologist has a far greater armamentarium of tricks that he can do because he can go to the edge, because you know where the edge is. The edge is where you can safely go and keep the patient without causing trouble. Without all that good monitoring you never knew where that edge was, and so we did things by the seat of our pants. There were a lot of things that we didn't do simply because it was beyond the capabilities of our skills to manage them.

When I look back at it, I just can't believe that I did what I did twenty-five years ago. It's amazing. Then I talk to the younger anesthesiologists, and they say, well, we've got to have this and this and this. No, I don't. You've got to have this kind of fancy monitoring on the heart if you are going to do certain surgery. Well, no, I've done hundreds of those cases without it. The patients all survive, and they've done well. Because I have other skills that were generated and developed at a time when I didn't have the electronics to support me. I had to develop the observations skills that you don't need today.

You mentioned you did a lot of pediatric anesthesia. Is the edge closer when you are working with smaller persons?

Yes. If you were to stop breathing, you've got a big lung full of oxygen; you can go

some period of time without any problem. With a little kid, the lung mass is so much smaller relative to the total body mass that their reserve, their margins, are much smaller and things happen quicker with kids. I've done infants and babies that weigh less than a kilogram. A kilogram is about 2.2 pounds, so they were like a pound and a half, a pound and three quarters. That's a little bitty — you know what a pound of butter looks like? Well, this kid weighed less than two of those.

Those are learned skills, and you become very, very precise in what you're doing. Right now in my life, I am so far removed from it because I haven't been doing kids on a regular basis, that a year or so back, I had a three-year-old scheduled for surgery, and I lost sleep about that the night before. I hadn't done a little kid in such a long time. In the morning I told the surgeon, "This is crazy. If I have to lose sleep because of my anxiety about a case, I shouldn't be doing it." I asked one of the other guys to do the case, and he did, and I don't do little kids anymore. It's a dramatic shift from what I was twenty years ago. But that just happened. I got to the point where I lost those skills that I had because I didn't use them. I just don't do small children anymore.

Are you occasionally involved in the evaluation of a patient as to whether or not they're a suitable candidate for surgery? You mentioned pushing the edge and knowing how far you could go, but there must be cases where you can't do it.

Well, a lot depends on the surgeon that you are working with. Surgeons vary all over the map in terms of their own skills and in terms of quality of their judgement, whether it's good or not so good or marginal or whatever. When I'm working with surgeons with good judgement, I don't have to worry.

They work the patient up and evaluate, so they know whether it's appropriate or not.

There's been only one time since I've been here at Carson when I've been working with a surgeon that I consider good, that I've had sort of a discussion over whether we should do the case. It was with an emergency situation, and he didn't know the patient, and I didn't know the patient. At two o'clock in the morning an eighty-five-year-old man had a bowel obstruction and was going to die. He was in the intensive care unit; he had tubes in every orifice of his body. He had several pumps that were pumping drugs to keep his heart going. He had all kinds of things; he was dying anyway in a sense. I thought, "Oh, Lord, why should we take this man to the operating room?" I had about forty-five minutes before the surgeon got there.

Now this is an area where Dr. Scully is an expert; that is the ethics of medicine. What was my responsibility to the patient? I didn't feel that it was in the patient's best interest to take him to the operating room and for me to kill him on the table, because that was exactly what I thought was going to happen. He was just being supported by too many high-tech drugs. With his physical condition, what was the point of putting a wound in his belly and just adding to his problems? Certainly, we could relieve the bowel obstruction. I looked at the bowel obstruction and said, "This may be the thing that leads to his demise, which is what he needs now." There's a time to live and there's a time to die. I deal with death differently than a lot of physicians, having experienced it so much as a youngster, in terms of my family.

I talked to the family, and I said, "This is where we're at." I had all this done by the time the surgeon got there. When all was said and done, he agreed with me, and we did not do the case, and the man died in about

twenty hours. But the surgeon was somebody I respect very highly. I've had surgeons that I've had very little respect for; we've had some real battles over cases that I just flatly refused to do.

One was a similar case, a ninety-year-old man with a broken hip who needed orthopedic surgery. The surgeon wanted to do it, and I said, "You are crazy; there's no reason to do it; this man is dying." One of the newer anesthesiologists did the case, and I said "Well, I can't tell you what to do. You have to make your own decision. But this is the decision I made and why." The man died six hours after the surgery was over. You just run up the bill; that's all. Those are some of the dilemmas of the high technology.

How do you feel about the family's involvement in making a decision? Is your responsibility to tell them and let them make it when emotion is involved?

I am very matter of fact about it. I say, "Look at it, you know, your grandfather is in the process of dying. If we operate on him, we may fix the thing that we operate on him for, but we are not going to fix him. He's got his pain under control right now. If we take him to the operating room, what we are going to do is run up another twenty thousand dollars in bills. We're not going to contribute to his quality of life and probably are not going to contribute to his length of life. We probably are not going to contribute in any way that's good except deal with this one little problem." And I say, "Again, I believe there is a time to live and a time to die, and his time is now. You really need to think about letting him do what he needs to do. He has lived a long life. And there's nothing left for him to do." Most families accept that kind of thinking and don't have any problem with it.

A lot of physicians can't talk to people. There was a lady, a young lady — we opened her up, and she was full of cancer, and we closed her up. The surgeon didn't tell her that she had cancer. The next day I went into her room, and her husband was sitting there and he knew, but she didn't know. Ultimately, we ended up telling her, and the two of them could discuss their situation. It was a great relief to him to have his wife know that — at least they could share what they had to share. I was very angry with the surgeon. I thought he did the patient a major disservice. But he couldn't deal with it, and that was his problem.

Where do ethics come into a situation like that if you have a number of physicians working with the case? Whose responsibility is it?

Well, the primary care physician — I don't mean that in the context of when we talk about primary care physicians in general — I'm talking about the physician who is primarily responsible for the patient's care at that particular moment. In this case it was a gynecologist, but the patient may be receiving their "primary care" from a family physician. In that particular case the patient was admitted to the hospital by the gynecologist, and so he was the physician primarily responsible for her care, and it was his responsibility, not mine. In this case he abdicated it, and so I did what needed to be done.

Was there a conflict with the physician because of this?

Well, I didn't kill him; I threatened him.
[laughter]

Did he feel that you shouldn't have stepped in?

No, I think he was just grateful. No, he never said anything — I told him what I

thought. I said, "Don't let it happen again!" And that was it.

You mentioned that anesthesiology is different from other areas of medicine because of the relationship with patient; that it's a little more difficult to establish relationship.

Well, up to a few years ago the patients were coming into the hospital the night before, and we would make what we call evening rounds and go around and see the patients. Now the patients come in the morning of surgery, so I do my evening rounds over the telephone. In the current environment the challenge is, one, to find out as much as much about the patient as you can over the phone, in terms of what you need to know to make your decisions in planning for what you're going to do in the operating room. Secondly, to apprise the patient of what's going to happen and answer any of their questions. Overriding all that is the need to make the patient feel comfortable with the fact that you're the one that's going to be giving them their anesthesia the next day. That is a tremendous challenge to do that in twenty minutes or so; to make someone who has never met you comfortable with the fact that they are going to be placing their life in your hands the next morning, that they feel OK about it. It's a big deal.

Is it difficult for you to get to know these people. Do you feel a little bit disconnected sometimes?

It varies from patient to patient, and it has to do with their personality and, I guess, how I feel at the moment, too. Whether I'm tired or enthused or whatever. Patients will ask me, many, many times, "What are you going to use? What are you going to put me to sleep with?" Well, you see that thing on the shelf there, the wooden thing?

Oh, the hammer, the mallet? [laughter]

I say I have a big hammer. Most of the time, nine out of ten times, that will get a chuckle out of the patient. What we have to do is introduce a little levity in what's going on. Then I can say, "This is what I'm going to do, and this is why," and some discussion about the kinds of drugs in terms of what they do, rather than names, because most patients don't understand the names. Pentothal — people say, "Well, I've had pentothal before."

I say, "Yes, that lasts three minutes. That's what we all use to put you to sleep, but then you will get other drugs and gases to keep you asleep after that. Then you'll wake up quickly after the surgery is over."

So, we talk about a lot of things. One of the things, particularly with surgery later in the day like one o'clock or something, they have always been told nothing by mouth after midnight. Well, there is lots of new information out that says it isn't necessary to do this. The patient should refrain from solid food five or six hours prior to surgery and liquids a couple of hours prior to surgery. Depending on the surgery: obviously, if you're operating on the stomach or the bowel and they've taken preparations to clean it out, you don't want to throw hot dogs down on top of that. But with that judgement I tell the patients, "Have your breakfast, and then just before you leave the house to go to the hospital, make sure you drink a couple glasses of water. You will feel better. You won't be dehydrated; you won't be so hungry; you'll feel better." They do better in surgery because they're not dehydrated, and it makes my job easier. They're pleased now that I call, because they can have a cup of coffee in the morning and at least start their day off in a more reasonable fashion. Then we talk. Sometimes we just tell stories, discuss common interests, or whatever.

I try and deal with what they're anxious about. For instance, we do a lot of breast biopsies. We're doing a breast biopsy because the woman's got a lump. So, is surgery a big deal? No. Is the lump a big deal? You bet. All I can do is reassure these ladies about the anesthesia and the surgery. It's usually local anesthesia by the surgeon; I give them some sedation to help them through it.

I usually talk about their anxiety about the process. I would say the vast majority, 95 percent of the patients, thank me for the phone call because it's helped. The next day when I see them, I walk in and my voice is easy to recognize. As soon as I talk to them, they say, "You must be Dr. Snider." But we are already friends in a sense; well acquainted. We've had a serious discussion that took whatever time it needed to take. Sometimes it could be forty minutes; sometimes it's only ten minutes.

You taught at Stanford for a while, then were in private practice. What brought you to Carson City?

During my residency one of my acquaintances from my medical school days, Bob Dempsey, started a company called Neurodyne-Dempsey, making testing equipment for medical electronic devices used in the hospital. They started out with devices for making sure that the equipment was electrically safe; then we got into calibration devices as well. The company is located over here on the other side of Carson. And it is still number one in the world in its product line, with about 70 percent of the worldwide market.

This started in his garage and moved to larger facilities. I was vice president of that company. So when I was in San Francisco, a gal that was an anesthesiologist wanted to

cut back and work two days a week. I worked three days a week at the hospital to cover the five days, and we split call appropriately. In the two days that she worked, I flew up to Napa where the company was located and worked with them. Bob Dempsey decided to move the company to Carson City for climate and tax advantages.

I started looking around up here and found they needed an anesthesiologist. They needed one right away, so I moved up here and resigned from the company; the company moved up a year later. I went back on the board of directors, but I did not become an officer again. So I was in a full-time practice of anesthesia, basically, once I came here.

Do you remember your examination experience with the Board of Medical Examiners when you obtained your license?

As I said, I was in practice in San Francisco at the time. I was flying in, and it was convenient for me to travel back and forth flying. In making my application, I was applying for licensure by reciprocity, and I was told that I would have to take an examination in microbiology. It was an exam by the state of Nevada because the California licensing exam did not adequately cover it. Now this is kind of an interesting thing to me. In 1974 I had been six years now in anesthesia, not having anything to do with microbiology, so I had to review. Microbiology wasn't just about bacteria that we're familiar with, but also such things as all the various worms and everything in central Africa, and stuff you'd get in Ganges River, and yellow fever in the jungles. It covers just everything in the world — tape worms, you name it; craziest darn things. What surprises me is that to this day I can still remember some of these names of these weird little critters.

So I did the review, and then I flew up to Reno. I took the written exam on the same day the Board met to examine potential licensees. What I didn't know is that I could have met with the Board and taken whatever exams they were going to give me at that time. I thought I had to wait for the score, which I did. I passed the written exam, but in the meantime my clock was running here, and I wanted to get started. Well, they had a process whereby you could get a temporary license, but you had to be interviewed by three members of the Board to do this.

I was visiting in Carson City, and Dr. Grundy was on the Board at that time. So I met him in the surgery lounge, and he asked me a couple of questions about anesthesia practice and what would I do in certain circumstances, how do I do this, and what's that. I was certainly on top of everything, and I answered the questions quite well. Then we sat down and chatted for a little bit about things in general. He asked me for a couple of good questions that he could use to ask other anesthesiologists who might in the future come along for licensing. We discussed some of the drugs I used. It was a very friendly, "hail fellow well met" kind of a thing.

I next flew to Elko where I met Les Moren, who was a grand man. We sat and had a pleasant conversation about medicine and where it was going, the practice of it, and things in general. He asked where I'd been and what I'd done and where I'd trained. About going to Carson City, he said, "Oh great!" Carson was a growing city, and he knew they knew they needed an anesthesiologist. It was that kind of a thing. My perception of that was that he just wanted to have a face-to-face with me and see that I was a reasonable person. Our meeting was fine, and Les and I have enjoyed a good relationship ever since. [laughter]

When that was done, I flew on to Reno, and I met with the grand old man, Ken Maclean. And Ken Maclean was very, very rude, abrupt and abrasive to me. I didn't understand this because I had never met the guy before. The first thing he said was, "Why are we having all this special meeting stuff? Why aren't we doing this in a regular meeting?" I explained to him the circumstances, that they were waiting for me to work in Carson, and it was going to be another several months before that I could meet with the full Board.

"Well, you know, we met at such and such a time; why weren't you there?"

"Well, I was; I was taking a written exam."

He said, "So you could have had the oral at that time."

That's the first I found out about it. So by my mere timing of everything, I had offended him. That sort of started it off.

He said, "You know anesthesiologists, they're a funny group." He said, "We got one anesthesiologist that used to fix a Demerol drip and put a needle in his arm and run it during surgery."

I said, "Well, OK, all kinds of people do crazy things, and that was one of them."

Then he looks me in the eye and he says, "Do you have a drug problem or an alcohol problem?"

I said, "I don't have a drug problem, but I have an alcohol problem."

He said, "Oh, what's that?"

And I said, "Well, I'm a pilot and I'm an anesthesiologist, and between the two it really cuts into my drinking time because I can't drink while I'm doing either." [laughter]

What was his reaction to that?

"Well, smart guy, huh?" [laughter] But, you know, it just made him understand that I wasn't there to take crap from him. I didn't

deserve to be insulted and verbally assaulted the way he was doing. He kind of settled down to business and asked me a number of questions. And then I left. The Board then granted me a temporary license. The next time the Board met, which was some months later, I had to go up to the meeting to get a regular license instead of the temporary one. The two members that I had not yet met came in and talked to me and said, "Well, we just wanted to meet you and welcome you to Nevada and wish you well." It was very cordial, and that was it.

You were active in medical politics when you came to Nevada?

I was involved in a lot of organizations from the time I was at Stanford through the time I came here. Nationally, I was on the Board of Directors of the Association for the Advancement of Medical Instrumentation. This is a group that started developing standards. I was with the American National Standards Institute National Fire Prevention Association; people who were writing the national electric code; all safety organizations on a national basis who I was involved with. I lectured all over the United States on electrical safety in hospitals, and presented papers on my own research.

That tied in your electrical engineering and anesthesiology?

Very much, yes. It was all governed by my engineering background. There are a lot of engineering principles in anesthesia, so it was a good marriage there for me, too. Once I came to Carson, then I got involved in medical politics. I was active in the State Medical Association, worked on numerous committees, and eventually served as

president. I was on the Board of Directors of the Nevada Professional Standards Review Organization, which was a government program at that time to provide quality assurance for health care delivery. I served as a trustee on the Board of Trustees of Carson-Tahoe Hospital for a year; I was appointed to fill a vacancy and was not re-elected to the position. The gal that beat me out had been here forever, and everybody in town knew her. I was on the Board of Directors of the Brewery Arts Center here, which is the arts center for the town. When they first established an airport authority, I was vice chairman of that.

Does the practice of anesthesiology lend itself to the flexibility that you would need to be involved in these other things then?

Oh, yes, very much so. My dealing with the patients is limited basically to the immediate pre-operative, inter-operative and post-operative period. And then that's it. If they have problems before or after that period, they usually are contacting their primary physician or the surgeon. So that usually once you walk away from a case, your connection with that is essentially over. There are some exceptions, but that's the rule. When I have things that I want to do, I get somebody else to work that day. I can take the day off and do the other things that I want to do. It's very different than handling an office practice where you have patients who are scheduled to come in, and you are committed to doing whatever it is that you do.

You don't need to maintain an office then, do you?

No. Only for billing purposes, and I hire that service out now. I did run a billing

company for years that did all the anesthesia billing in Carson. I also had a computer time-share service, and had a big computer connected with other offices.

So you don't have the overhead that is the bane of private practice? You would have to have malpractice insurance.

Yes, I have the professional expenses that any other physicians have. But I don't have the office expenses. No, my overhead is probably a tenth of what office expenses are, an eighth to a tenth of what one might otherwise have. But on the other hand my fees and services reflect that. A surgeon has to pay for his overhead and pay himself, too. So that is reflected in his fee structure.

How is the anesthesiologist chosen? Are there certain physicians you work with? Does the hospital say, "You are on this day"?

No. For years we had the Carson Anesthesia Group. I was the first anesthesiologist here. There were two nurse anesthetists who had been here for years and years and years — in looking back they were old ladies. [laughter] I think they were younger than I am now, but at the time they were old ladies. And they were very, very much out of date; they had just not kept up. One of the surgeons had asked the nurse to please monitor the heart, and she told him to mind his own business. So he called St. Mary's Hospital in San Francisco and said, "Is there anybody down there that can come up and do anesthesia here?" And that's how I made contact with him and moved up here a year before the company that I was with did. But it was that kind of thing. So I brought modern anesthesia to Carson.

What year was this?

1974.

Until 1974 they didn't have an anesthesiologist?

No, just the two nurse anesthetists — Steve Panter, who was a nurse anesthetist, came three months before I did. He was totally up to date, but he was not in a position to do anything about the problems. Whereas as a physician, I had the authority to make recommendations to the staff. We got changes made, got rules and regulations in place; they still are there today without much change. I feel pretty good about that; my original judgements passed the test of time.

At any rate, as we added more and more anesthesiologists to the staff, we formed what we called Carson Anesthesia Group. We would just make sure that we had a calendar. If somebody wanted off, they had their name on it, and it was sort of first come, first served. We scheduled people in the operating room around that. But surgeons did have their preferences, and if they didn't like to do certain kinds of cases with a certain guy, then we wouldn't schedule them. Beyond that, though, we were in charge of who did what when and that worked out very well.

How different was it coming from a big city, big hospital to Nevada? You were breaking ground really for what you wanted to do.

Well, it was interesting. I lived right across the street from the hospital. I was the closest physician to the hospital. We had no emergency room staff; we had no interns or house staff, so any time anything went on in the hospital I was the one who was called first. If there was a code or there was any kind of a problem, they called me because I could get there before anybody else. It gave me the opportunity to teach them what an anesthesiologist could do, what our

role was in the hospital. It was serendipitous that it happened that way. But it really did give me an opportunity to introduce people to the specialty of anesthesia as a physician's specialty. And I ended up with really a good experience.

Did you have any level of frustration because of lack of facilities?

No, because I owned all my own equipment, and I brought it with me from San Francisco. In fact, there was no electronic monitoring of blood pressure in the hospital. So whenever they had an arterial line in where they measured the blood pressure directly, they would borrow my equipment for the ICU to use it. If I had an emergency in the middle of the night, I had to go retrieve my equipment from the Intensive Care Unit. Now, our ICU is as good as any anywhere in the world. Everything is totally modernized. All our anesthesia equipment is all brand-new; it's all state of the art stuff. Things have changed a lot.

You were on the Board of Medical Examiners from 1987 until 1992. How did that come about?

A friend of mine was on the Board, and he was resigning. He called me up and he said, "Del, would you be interested in being on the Board?"

We had discussed this a year previously with some people, and I said, "Yes, I wouldn't mind serving." So about twenty minutes later Governor Bryan called me and asked me if I would be on the Board. I said, "Yes."

He said, "OK," then followed up with all the papers and all the rest of it. That was a four-year appointment, and Governor Miller was in then. I submitted a letter to him and requested that I be reappointed and did some rationale for that, and I was reappointed.

When I felt that I couldn't serve any longer, I sent in my resignation. One of the physicians in Carson City who had been doing chart reviews for us had expressed an interest once. I asked him if he was interested in sitting on the Board, and he said, "Yeah." So I submitted my letter of my resignation to the governor, that took about a sentence and a half, and then I spent the rest of the page extolling the virtues of this other guy and why he should be appointed in my place. A couple of months later my resignation was effective, and this guy was appointed in my place.

It seems to me that in the last ten years or so the function of the Board of Medical Examiners has become increasingly complex. Is that accurate?

To my knowledge, yes. In 1985, there was a major change in the licensing act. It was completely re-done, and at that time the Board was given expanded authority and autonomy. One of the critical things that came out of it was that the Board could create an investigative committee which could work on a confidential basis. What this meant was that the investigative committee's activities were not discoverable in court, so that they could work with the freedom of knowing that whatever was said and done, and whatever records were generated as a result of the investigative committee's work were absolutely confidential.

What this allowed was an incredible amount of freedom with the ability to call physicians in for cause. Somebody would file a complaint, and the investigative committee would look into that, whether it was getting charts in the hospital or charts in the doctor's office or checking pharmacies to see what kind of prescriptions were being filled, or whatever. If it was a complaint about substance abuse the investigative committee would go ahead

and authorize urine samples to be obtained, or blood samples to be drawn, on a random basis. Those findings were all kept absolutely secure. Whoever filed the complaint was kept confidential. Occasionally, from the nature of the complaint it was obvious that an individual was involved, and then it couldn't be helped. But to the extent that we could keep the complainant's identity confidential, we did.

But you bring a physician in and discuss it, and let him know that whatever was said there was not going to go beyond those walls. Many times a physician would say, "Well, I want to bring my attorney." He can, but it's not necessary; nothing is going to happen that an attorney is going to change one way or the other. Typically, when the attorneys would come in, we would tell them that they were a guest of this committee. They were there to hear what's being said, but it's not a court of law, and it's not even an administrative court. It's just a meeting between the investigative committee and this person. The attorney is there by tolerance, in a sense, and has no part in whatever goes on. If the attorney has questions, he can certainly ask them, but this is between the Board and the physician.

We tried to explain the delicate relationship that went on there: that this was not a place where the physician needed representation. Nobody seemed to ever believe that, but when the meetings were over, then they understood what was going on. For the most part we were just trying to get the other side of the story.

You chaired the investigative committee?

For three years.

Could you tell me what a meeting would be like? You don't have to use specifics, but was it informal?

It's pretty informal. We got about sixty complaints a month. The Board staff would provide each member of the investigative committee with sort of a précis of the actual complaint and then some information about the physician — his education and his training; where he lives; what kind of practice he has; where he was licensed — sort of the demographics of that particular individual and anything else that might be relevant. For example, if it had to do with prescription writing, then we would have copies of the prescriptions that had been picked up at the various pharmacies. We might have one or two pages on that particular case, or we might have a quarter-inch stack of information.

If there were cases that required review, somebody had to go look at the charts. Those charts were usually sent out to an outside physician who was paid on a per hour basis by the Board to do chart review. I used to do all the chart review, and it was more work than one person could really do. So we had physicians in the north and the south that would do this, and they would dictate a summary of their findings from the chart, what the facts were as they gleaned them from the chart, and then some qualitative assessment of what they saw.

Most of the time what you saw was a case where the patient was unhappy because of the outcome, but there was nothing wrong. The physician did everything he could, and the care was appropriate at all points in the case. There really isn't anything to say; this just doesn't always work, that's all. On the other hand, we would get a case where they cut the wrong lung. That's not something you can gloss over. And there were the in-between cases where a patient bled a lot; had complications. The guy went on vacation and turned the case over to somebody else, and he didn't understand what was happening

and ended re-operating on the patient. The patient died, and then that becomes a very complex case. Not only would we send it out, but we would probably end up sending that for review to several different physicians in the specialty that's involved, not just our reviewers.

Most of the complaints were related to charges and fees. Almost all fee complaints were related to unhappy relationships. They didn't like the way the doctor talked to them, and so they complained about the fee. Those kind of went hand in hand. So what we have is what we call the demeanor problems. If it's the physician's demeanor in his office, usually those reflected themselves as fee complaints. Sometimes it would be, "The doctor was rough with my child."

We would call the doctor in, and he would say, "Hey, you should have seen this brat. He was an out-of-control kid. I had to examine the child, and the child was fighting, and the parents were fighting, and it was a bad scene. I did what I had to do; I had to just physically take a hold of the kid and hold him still so that I could do an ear examination," or whatever it was. "The parents — their appreciation of that was that I was mishandling their kid."

For this case we had Dr. Scully on the committee, and he was trained as a pediatrician. It was great, because a case comes along like that and he would say, "I know exactly what the guy is thinking. You've got to do that sometimes."

So we would say, "All we can do is advise you what you already know: perception becomes reality, and the patients view you as mishandling their kid. That's what they really think happened." You can't even tell him to go and sin no more because he really didn't sin. There was really no issue that the Board had to deal with there; it's just part of the vicissitudes of life.

When it came to pharmacy issues, we would discuss having a physician take further training. Pain management was the main thing. Physicians weren't trained in dealing with chronic pain, and so they would get patients hooked on drugs. They were over prescribing just simply because of ignorance, not because they were bad people. There are numerous programs now to teach physicians how to deal with chronic pain, and we would ask these guys to go take some continuing education in the management of these patients. In the meantime, get a pain management specialist involved in the care of this patient. Call in a consultant and get some help.

Most of these guys, when you present them with the facts, say, "But, yes, you know, this case is really beyond me at this point. I don't know what to do. I've done everything I know how, and this is where I'm at. And I'm kind of stuck with it."

So then we ended up helping the physician help himself, helping the patient in the long run. And again, there was no disciplinary issue here. The guy was trying. He got in over his head, and we helped bail him out and sort of gave him a strong invitation to get some continuing education. If he didn't get it done, then we could go on and say, "Look, you have a choice here now: you can either behave responsibly or we are going to have to look at this in more detail." Most physicians are disposed to doing the right thing. Nobody likes to get caught in a situation where they look bad, but once they've done that, they are certainly eager to accept help to get out.

I viewed it as a very, very good process because the complaints could be filed and we could deal with them. Those that weren't a problem, put those aside. The ones that were slight problems, deal with them at the level they needed, and then spend our time with

the serious ones. Sometimes it was a matter of defining a strategy on what we would do in the way of further investigation. We have well-trained investigators, experienced people. The one in Las Vegas, the last one we had, was an ex-policeman, and he knew everyone in the drug enforcement agencies. He knew how to work his way through the courts. And he knew how to get the information. He worked well with the other agencies so that if he needed some help from the DEA, he could get that. Or the Nevada State Board of Pharmacy — he worked with their investigators. They did a lot of sharing and helping each other. So that worked very well.

But as I say, most of the time we'd look at our record and would say, "Well, this doesn't need anything," and then we'd put it aside. Sometimes we'd say, "Well, this guy needs a phone call. Well, do you know him? Do you know him?"

"Yes, I can call him and just talk to him about it."

"Hey, we've been getting a lot of complaints about your temperament." We know the guy's a good physician. In one case, I'd personally known the man for years and years; he was a highly capable guy. But suddenly there's a rash of complaints. Something was going on. Well, yeah, he was working too hard. So what he did was he cut back on his practice, and the complaints stopped; it was that simple. It wasn't that he was doing anything wrong; he was just in ill humor.

So this is the informal process. What if you ask someone to come in, and they ignore your effort?

I'm not exactly certain of the process, but I think we could subpoena them. We'd just explain to them that they are putting their

license up. It's the chip they're throwing on the table if they don't respond. I can't remember anybody that didn't eventually show up.

The ones that we felt merited disciplinary action someplace along the line, we'd say, "OK, this guy needs discipline." If somebody was a substance abuser, we would get him immediately back to Georgia on a voluntary basis. As long as they went on a voluntary basis, there was no public record, because we wouldn't make a formal complaint. But they were told, "If you don't go, we will file a formal complaint, and you will stand the chance of a suspended license or a revoked license. It's up to you; you can make the choice." I can't remember any physician that didn't make the choice to do the right thing.

Did you track the physicians who commonly have complaints in something that would be minor, but a pattern would develop?

Every time we had a printout on a physician, the bottom of the page also had the complaints that had been filed against him. Some of the public members would say, "Oh, this guy's terrible. Look at all the complaints that have been filed here." Well, the number of complaints has nothing to do with how good or bad you are. This is the same as the one guy that was a very good physician, was just overworked, and he was getting a lot of complaints; nothing to do with the quality of his work; just the quality of his mouth. [laughter] But we did look to see if there were trends or whether there was something there. That didn't mean that we disposed of the records; it just meant that they went into a secure file, and there was no further activity being done on the closed case.

But when a case got to the point where we felt there was something that needed to be addressed, at the next Board meeting, in

closed session, the investigative committee would make a report. We would present a case and ask that formal charges be filed. It was sort of like a Grand Jury where investigators are presenting to the Grand Jury their information, and then the Grand Jury decides whether or not charges should be filed. Then in open session someone would make a motion, "I move that charges of substance abuse be filed against XYZ." Somebody else would second it and take a vote. All you got was the charges, none of the Grand Jury's work. None of the stuff that was in closed session came forth. All that would come forward in a public hearing at a later date. It's administrative law that follows civil law in many ways, but it is different. In this case the Grand Jury is also the judge and jury later on, which is quite different.

Do you see that as a potential conflict?

Yes, certainly it is. But at the same time I think the system works fine in that we had nine people on the Board, and they're all intelligent. Six of them are physicians, so they can understand the medical issues involved. The public members were certainly alert enough to view it from their own point of view and ask their own questions. Either the case that was presented was strong enough to convince everybody, or it wasn't. The fact that charges were filed just meant that there was enough information here to warrant going ahead with this at a full hearing.

Usually the charged physician was represented by counsel at that point. Our own counsel was involved, and our own counsel always sat at the investigative committee meetings. There were three members of the investigative committee, plus Pat Perry [the Board's executive director], and our counsel. One or two investigators might be there also.

So that's on the Board's side. That was an intimidating bunch of people for a physician to come in and sit there with sweaty palms, wondering what's going on with his life. But we would try to reassure him that we are just sitting there. This is his chance for him to tell his side of the story.

Are there certain charges that are red-flagged? I was thinking of physician impairment. That seems to be one of the serious problems that the Board deals with.

Well, physician impairment is serious in its own right, and it's serious because it's probably one of the bigger sets of problems that we have. But physician incompetency is also very serious. If a guy is doing things that he shouldn't be doing for lack of training or it's the wrong thing to do — someone doing chemical peels with household cleansers or something like that — I mean that's wrong.

How do you determine that? If a physician is using drugs or alcohol, you can check the urine. Incompetency is a judgement call. Where do you draw the line between an error because he's tired or outright incompetence?

There are several ways. One, sometimes their behavior is outrageous. It takes no rocket scientist to figure out that what he is doing is improper, as in the case of a guy who's doing chemical peels to the point where he scars his patients, and they're wounded for life. Then you go back to the track record, and you find out what he's using is something that was tried fifty or seventy years ago and found not to work then. He's had no training in it. He's working entirely outside of his realm of knowledge, and that's malpractice. So that's not hard to define. A guy in surgery cuts the wrong thing. That may be malpractice from

the point of view of a civil court, and we may view it as a mistake. People make mistakes. Regardless of what else we are supposed to be, we are human. And human beings make errors. Is this an isolated error? Are there mitigating circumstances? Again, like the physician that cut out the wrong lung. It was an isolated error. He was a very competent surgeon. This guy just cut out the wrong lung.

It really did happen?

It really did happen. I mean that's gross, absolutely gross. Should he lose his license over it? No. Should he be punished? Probably. The punishment that that physician had was his own nightmares. He had to live with what he did. He knew it was wrong, and once it was done there was nothing he could do to undo it. In other words, the gun went off. But there were a lot of mitigating circumstances. He had the chest x-rays in operating room, and the lesion that he was supposed to be going after was in this chest; there was also a spot on this chest. He asked the patient which side they were taking out and the patient said, "The left side." However, that was incorrect. He didn't bring his own office notes with him, and that was the error because all the information he needed was there. There were a series of things that went on that contributed to mitigating circumstances. But ultimately, he was responsible, regardless of all these other things.

That's a real gray kind of case. Clearly, he did something terrible. It's clear that what he did cost the patient's life. It's clear he'll never make that mistake again. We don't need to discipline him to prevent that from ever happening again. But an isolated incidence of that magnitude may have been the precursor of something else going on. That guy may have been losing it, and this is the first major

example. They put him on probation for some period of time, six months to a year, and they put him under monitorship at the hospital.

And how does that work?

That means he had another surgeon with him at all times. It put him sort of back on probation in terms of his privileges in the hospital. Well, his judgement was good, and there were no further problems, and so then by virtue of hindsight, you could say, "It was an isolated incident, and there's no reason to restrict him in the interest of the public good." That's what the Board is working for, the interest of health and welfare of the people of Nevada. There is nothing to be served for the people of Nevada to punish and restrict this physician any more. It won't serve any useful purpose. It won't undo what happened, and the public's future doesn't need protection because it was an isolated incident. So these are the kinds of judgement calls that the Board gets involved in. That's why physicians have to be a part of that to understand really what that means. A totally lay Board could not properly evaluate that condition.

You said earlier, that in a recent case where a physician lost his license, that you felt that might have been an error. This man was very competent, and if they had put restrictions on his license, you could still have a highly-trained, competent physician taking care of the public.

Yes, that's my personal belief. That was one alternative way to handle it. But the community feeling was so strong, that the public interest was best served by just taking away his license. That's a judgement call where I didn't agree with the judgement on it. But that's why they have more than one person making the decision.

You said you need physicians on the Board so that they will understand the circumstances behind what's going on. But what about physicians on the Board protecting the profession, the reputation of the profession? Do you think that's part of the Board's function?

No. I don't think so. I don't think the Board uses its role to protect the guilty. Certainly if someone is innocent, the Board doesn't want to get headlines in the paper that Joe Doaks has been charged with something that has no merit. That's why we have the confidential investigative committee work. But once it comes out of the investigative committee and becomes public charges, the public becomes aware that there is a significant event going on. I know historically that there is perception that the Board is protective of the physicians, that it was the good old boys club, and there probably was some merit to that. I think that some of that still goes on. I can remember a case where the investigative committee brought charges against a physician who was very senior, politically connected, well known, a long-time reputation, buddy of all the power people in the state. We brought charges up on it. The Board said, "No way!" That was it. It didn't take as long as it took me to tell the story to say, "No!" That to me was the most blatant case, and I felt that that was not the right thing. But on the other hand, the issue itself was not so great. I mean, the guy wasn't committing bathtub murders and getting away with it. I don't even remember what the issue was, as a matter of fact. All I remember is that the circumstance occurred, and I was relatively new on the Board, and I was still naive, I guess. That took me aback; I just felt that that was eminently unfair. But I am still second-guessing a lot of other people.

And at that point you acquiesced to their opinion, judgement?

No. I was on the investigative committee; we presented the case; they voted no. I didn't have to acquiesce or not acquiesce; I didn't have any option. All I could do was argue the case, and the case was argued, and they said, "No." A no vote; next subject. That's the end of it.

Was that the exception rather than the rule?

Yes, that's the exception. I had a great deal of respect for all the Board members; I think they were all highly motivated to do the right thing. Some worked harder than others; some were more prepared when they came to meetings; some put more effort into it than others. But all in all I felt that they were all motivated to do what they were charged to do, that is, protect the public interest. There were a number of times where our investigative committee did bring cases forward to the Board, asking that charges be filed, and the Board elected not to. But those are judgement calls. Once again you go to the Grand Jury, present your case, and the Grand Jury says there's no case.

How would the Board's work figure in a civil malpractice suit?

All the Board's activity comes under administrative laws and not civil laws. If I were a judge — I guess I shouldn't even say that because I don't know the law that well — but it would seem to me that the fact of what the Board did was purely irrelevant. I can give you a case in point. The fact that Dr. Minton's license was yanked by the Board acting under administrative law with a particular charter had no relevance in the civil

case that followed except that it showed that another body looked at this and said that they felt that he had done something that merited his license being yanked. In civil law hearsay evidence isn't allowed. There is a whole set of evidentiary rules and process that is so much more strict than it is in administrative law. The administrative law is a whole lot less formal than civil law.

Is it fair to the physician to use different standards in criminal versus administrative? To allow hearsay evidence versus beyond reasonable doubt?

Well, yes. The reason here is that you've got different circumstances than you would have in a civil court. In a civil court you are supposed to have a jury of your peers or whatever. But in the Board situation, you've got six physicians on that Board, people who are intimately familiar with what goes on in the practice of medicine. And they've got lots of standards. They've got the personal standard; they've got the standard of the hospital they work with; they've got the standards of the medical society, the community at large; what they learned in medical school; what they perceive as a national standard if there is such a thing; what's acceptable for danger, what's not; what becomes — sort of a fringe activity versus over the fringe. All these kinds of judgements, so that if somebody comes in with hearsay stuff, they're in a better position to weigh this than a jury, a civil jury, would be.

They can also attach credibility to it. I've seen so many people called before the Board to testify, and credibility was really the issue. In something like a sexual assault case or a case where the physician is sexually involved with the patient, the complainant would testify, and the stories were so different that it didn't make sense. It's a lot of work, talking

to lots of people, to sort through all this, to come to a decision on what was probably the real chain of events. It's not so much looking at the letter of the law as the spirit of what went on, because again the prime directive is still what is best for the people of Nevada. So there have been a lot of judgement calls, but the point is that you have people who have demonstrated good judgement; they are there to make judgement. I think the system is good the way it functions.

Were you always aware of these responsibilities? Is it a burden, being on the Board, judging your peers?

I had volunteered to be on the Board, and it takes a while to learn the process and understand the law. You had to become familiar with the process; how the Board functions and how to wade through the paperwork that you do. What really killed me is the learning about bad physicians. I thought I belonged to a very noble profession. And while I guess I had seen a few bad apples come through Carson, they didn't last long here; the town was too small. In the first ten years that I was here we had about one physician a year come into town and leave fairly quickly simply because they were not good doctors. I was totally naive when I got on the Board and saw the depth and breadth of things that physicians could do. It was devastating! It was the hardest thing to deal with for me. It was a heart breaker. In a way I was angry with the physicians that were transgressors because I felt not only were they betraying their patients and betraying that trust, they were betraying the profession as well. They were betraying me, and they were betraying every other one of their colleagues. They were bad people. I didn't make any attempt to hide my contempt for them. I had

no respect for them, and I let them know that I had no respect for them. I thought they were animals, and they deserved whatever the law would give them and probably a whole lot more. Beyond that, the work of the Board, being on a working committee, wasn't particularly burdensome. But working on the investigative committee did take a lot of time, and it was literally like 10 percent of my life. A year was spent working just on Board activities. It's a long time.

It's a large commitment, a very large commitment. And the salary was tremendous — I think when I left, the Board members got eighty bucks a day for having a Board meeting, and our work was really worth three hundred dollars an hour. For anybody that was a lot of work, a lot of responsibility. The secretary of the Board was paid a salary of twenty thousand dollars a year, maybe two thousand dollars a month. When I was secretary, I spent one day week up in Reno. And then all the other meetings as well.

What did you do as secretary?

I did all the chart reviews. When Tom Scully took over as secretary, he recognized that his demands up at the university wouldn't allow him to spend the kind of time I was. Furthermore, he had not been in clinical practice for a long time, and he felt that he was not qualified to make the kind of judgements about clinical practice, so he set up a network of physicians that would review charts, and that took a lot of the burden off there. The secretary was also the chairman of the investigative committee. Those were the two main functions.

Before you came on the Board, as a practicing physician, what was your perception of the Board? Did it change after you had served on it?

The only thing that changed for me was learning what an incredible job it was; that the Board was a very active board; that the new laws had provided it with a totally new, different posture in the state; that the licensing functions were very, very different than when I came to Nevada. In fact, if I were to come to Nevada now, I could not get a license.

Why?

I don't qualify, I'm not board certified. I have not passed the national boards for students. When I graduated from medical school, national boards were just invented. We had a choice of taking the national boards or, since I graduated from the University of California San Francisco, of taking the California boards. Well, California boards were accepted worldwide. So I opted, as most of my classmates did, to take the California boards. But as years went on, the move was towards the national board system, so that every graduate of every medical school in the country took the same examination. With this uniformity of examination all states could use that as a measurement of some sort of level of performance and knowledge, which was fine.

For me to get into the system I would almost have to go back to school again, which I couldn't and wouldn't do, to re-qualify to take the exams. So there's no way that I could enter the exam system at this point to become eligible for a Nevada license. A block to some older family/general practitioners is the new law that requires three years of postgraduate training to get a license now. My understanding is that most states are adopting that portion of the Nevada law. So, changes have occurred over time.

The issue of oral examination was brought before the Board during your tenure.

The oral exam was a nightmare. The statute requires the Board to evaluate each and every candidate. So the Board said, "OK. What we'll do is we'll have an oral exam." We had two exams, one written and one oral. The written exam was just a questionnaire on the law, open book. The questions were directed, so we could say to every physician, "You actually read that part of the law. We know you did, so you can't plead ignorance of the law."

The second thing was sort of an indefinite evaluation — in a matter of say twenty to forty minutes — to ask them questions and try and select out people that might not be suitable. They may be perfect on paper, but not so perfect in person. The way the Board addressed this was by getting urologists to talk to urologists and having anesthesiologists talk to anesthesiologists and so forth. I mentioned those two in particular because what was happening was they were getting very, very stringent. They were asking questions as if the examination was for board certification in a specialty. The candidates weren't expecting this kind of exam. No other state did this. We had one guy who flunked his oral exam. Two urologists said, "This guy should not be given a license."

The guy was in tears in front of the Board. We talked to him, and he said, "I don't understand this." He said, "I just got board certified two months ago. And they are telling me I'm not competent to serve."

Well, you start hearing a couple of those We got an anesthesiologist who was an assistant professor at the University of Utah. He flunked; couldn't get a Nevada license. So we said, "Well, what's going on here? There's something happening that we didn't intend. We thought we were doing the right thing." The president of the Board and myself — or somebody else; I forget who — went and

interviewed him ourselves. We found him to be personable, presentable, knowledgeable, able to answer questions; he had a good thought pattern and process. On the basis of credentialing and on what we saw, we couldn't see any reason to deny him a license.

At that point we really started having second thoughts about the process that we were going through. Then we looked at the law again, and the law says that the Board shall make the determination. We were having these other people making the determination, not the Board. So we decided that we needed a change, and what we did is altered it so it was not so much an examination of their clinical knowledge. Nobody got to us without having demonstrated competency, they were credentialed, they'd gone to medical school. They had taken all the other exams. We didn't need to examine them on their specific medical knowledge because that had already been demonstrated. All we really wanted to know was that they weren't crazy; that the person represented is the person that is there, and that was pretty much the kind of thing that we felt we needed to do at that point. We had to make sure that the human side of the equation was looked at. And we could do that.

We devised a questionnaire that was fairly simple. "What are the five leading things associated with heart disease?" or, "What are the tests for uterine cancer, breast cancer, lung cancer, prostate cancer?" Then we threw in some hooks like lung cancer. Well, everybody said, "Chest X-ray," but there isn't any screening test. And then a simple case presentation. One that I used a lot involved other students. You've got a twenty-one-year-old sexually active female, who comes in with regular quadrant, pains in the belly. She's got an elevated white count; she has a fever. What's your differential diagnosis?

Appendicitis? Ovarian cyst? She's sexually active. Could be a tubal pregnancy; could be gonorrhea, pelvic inflammatory disease. The ones that missed that the most were the gynecologists because they went into all the esoteric stuff. They missed the obvious.

The whole point of that process now was that the Board members themselves were doing it. We did not have the public members of the Board do it on their own. We had a physician with them. They would ask questions, we would ask questions, sort of back and forth. But it didn't put a public member in the position of having to make a judgement without really having the background to be able to do that. We usually conferred, and I never saw a problem working with a public member. Every time I was involved in that, we saw the same things and we agreed on what we saw. Then I enjoyed that process because 99 percent of the people you talked to were bright, young new physicians. They were eager, and they were enthusiastic, and it was nice to see that. It was such a contrast to the investigative committee side of things. There you were dealing with scum bags and all the rest of this, and here were all the bright, fresh faces that were eager to go out and do the things they had been trained for a dozen years to do. I found that part, the licensing side of it, very, very refreshing.

What were you looking for? Essentially you are evaluating someone's character, personality, with this type of meeting.

Somebody who is depressed; somebody who is dysfunctional. Mainly we are looking for, I would say, psychiatric, mental, psychological disorders.

And you can see that just in an interview?

The things we are looking for are so gross that they jump right out at you. We would have this person sit in front of the Board, and their effect was so bad that the Board's recommendation was, "Look, Dr. Jones, it's obvious to the Board right now that you are disturbed. You really should get this fixed before you try and do much else with your life. When you've got it dealt with, then come back and seek licensure. The rest of your record looks good. We will be happy to consider you again sometime in the future. But get your life in order." It was that kind of thing. This was not disciplinary or anything. We were basically doing the person a favor.

There are numerous cases where people misrepresented themselves when they applied for licensing, and we found out about it. Sometimes it came out at the time, when we were doing these orals; sometimes it was later on. All you have to do is lie on an application, and you lose your license. Sometimes you find out in the strangest way. We had one person who had misrepresented her credentials. One of our Board members was talking to somebody back east at a university, and said, "Oh, yes, we just licensed this gal who had been in your program."

"Oh, yes, we kicked her out."

"Did you? Well, that isn't what she said." That's real serendipity. We explored it, found out that she lied, called her in, took her license away; just that simple.

We had lots of cases where people tried to misrepresent the things they had in training, that they had met the requirements when they really didn't. This mainly involved south of the border type colleges: the Caribbean Islands and South America, Central America. They would come and do clinical clerkships in the United States for employment. But these were not approved; they couldn't get credit for them. Sometimes they would try to misrepresent. They were denied licenses.

What if the Board looked at somebody and said, "This person's got a problem"? And denied a license because they felt there was a problem. Did somebody have grounds for a law suit if something like that happened?

Well, people can sue you anytime for anything. One of the things that we had to keep reminding ourselves was that we had to do our job; the fear of a law suit should not prevent us from doing our job. That was a risk that you always took if you made a decision that was adverse to someone's personal interest, but you still had to make that decision in the best interest of the people in Nevada. That was the whole point of it.

The number of people that we did not license on this basis were few, but the ones that we did, there was no question they should not have gotten a license, at that time. I can think of a few instances they might have argued a little bit about it or protested, but in the long run they accepted the judgement of the Board. They knew the Board wasn't telling them anything that they didn't know. People know when they are not well for the most part.

Are the medical education standards, standardized enough across the United States that you would be able to judge an applicant based on credentials?

We used to have Class A, B, C schools years ago. Now all schools are all accredited by the same accrediting body. That means that they all have to have the proper sized libraries; they have to have the right number of qualified professors; they have to have the right kinds of laboratories; they have to have the right kinds of clinical materials available for the students; the community that they take their training in has to have enough variety of pathology that the students can be exposed to things that

they need to encounter. There has to be an adequate amount of research; the funding has to be there — there are so many things that they look at. They look at scores and tests, so that basically there is just one standard and everybody marches to that standard.

Now there are other outside organizations that will evaluate schools based on a whole bunch of other things. For instance, the University of California, San Francisco, and the University of Nevada, Reno, medical schools cannot be compared. One is a humongous institution that has nursing, gynecology, Ph.D. candidates; every kind of lab for anatomy, physiology. They have research facilities that go on and on. Research facilities in medicine alone that are bigger than UNR. So in terms of just the size of the institution and the incredible resources that it has, the faculty and students, thousand and thousands — there's no comparison. But in terms of the quality of physician that comes out, you can compare. You take the individuals, the product that comes out of the institution, and compare the product. The product that comes out of UNR is pretty damned good. The product that comes out of U.C. San Francisco is pretty damned good. So you can look at institutional differences, but the curriculum for the medical schools are such that the graduates of those schools can be compared, and they compare pretty well. UNR does very, very well.

One question I wanted to ask you and it fits in nicely here. Thank you. The idea of Continuing Medical Education for a physician, how do you feel about that?

Well, the entire time I was on the Board it was mandatory. The reason for this is that it's the only thing you can measure. There are different classes of continuing education,

from reading up to going to formal meetings. A formal meeting is the highest level and it's category A CME. The law demands that every physician have twenty hours of category A CME every year. Since we have a biannual registration or reissuance of licensing, that means forty hours every biennium. It doesn't have to be twenty hours in each calendar year necessarily. But you do have to have the forty hours in the biennium, and you can have it all in the last month, for that matter. It doesn't matter. It makes no difference whether you have forty hours or four hundred. If you have four hundred, the Board doesn't want to hear about it; they only want the documentation for forty.

This is a political thing. The legislature did this because now it made the physicians accountable in some way for continuing education. These laws were passed across the country, so CME became a big deal. CME is worthless in accomplishing the goals that it was meant to accomplish. I can go to a meeting in Hawaii, for instance, and sign in. As part of my registration package is my name tag and badge, my admittance tickets for all the lunches, dinners, parties, whatever is going on. In Hawaii it's a week-long meeting, and they meet only in the morning. You have the afternoons off to play in the sun and enjoy being there. Also in the package is a certificate of attendance. So now I've got my certificate of attendance for seventeen to thirty hours of CME or whatever it may be. Every morning, then, go in and sign the sign-in sheet, and then go scuba diving or whatever else. You don't even have to go to the meetings. A lot of organizations recognize that, and so they started handing out tickets for each meeting, and you had to present the ticket, or they had a sign-in sheet for every hour or something where they put in a little more control. That perhaps gets people more into it, but then somebody has to go back afterwards

and go through each of these — find every physician's name among the hundreds and hundreds that may be there. Then deal with, "Oh, I was there, but I forgot to sign in." That kind of stuff. Then generate a certificate and mail it to the physician later. The overhead for doing that was just awesome.

Physicians learn from those formal CME things, but that's not the primary place that physicians learn. The primary place that physicians learn is from talking to their colleagues. Secondly, is from their reading. Way down the list some place is this formal CME. What I learned at most CME functions was that I'm doing the right thing.

They go through a lot of process, and they discuss all kinds of new and interesting stuff, but little of that's reached the level of the practitioner. The bottom line is that the new things are not in current use. I am using the modern drugs, I'm using modern technology, and I'm up-to-date on everything that I do. Anything new that I'm not doing hasn't reached the point that I should be doing it. A lot of review stuff is very esoteric, and for that period that you are sitting there listening, it gives you a lot of insight into some of the things, particularly pharmacology, and the way the new drugs work. By the time you get home you've lost a lot of that, and it's not something you think about every day. It's not necessary to know those things to be able to use the drugs. You don't have to know what makes a coffee pot work to make coffee.

Yet this is something that is imposed. When the Board first started talking about mandatory Continuing Medical Education, overwhelmingly physicians were against it. Do you think the expense is part of it? Are there inexpensive ways for physicians to get CME, so they don't have to spend a week in Hawaii?

I go to a meeting that the Arizona Medical Society of Anesthesiologists puts on. Arizona, Nevada and New Mexico, I guess, form sort of a little group. I can go down there, and my fee is fifty dollars. I stay in Scottsdale, which is not cheap. The rooms are around a hundred and thirty to a hundred and fifty dollars a night. I stay there three nights, so it's four hundred and fifty bucks plus a couple of hundred dollars in air fare to get down there and back and maybe another hundred dollars in meals. So to do that, it runs around seven or eight hundred dollars for three days. Plus the loss of income. On the other hand there was a meeting, a leadership meeting, of the State Medical Association this last week, and I don't know what the dues were, but they were around eight hundred dollars for the fees. So it would have cost me like fifteen hundred to two thousand dollars to go down for the three-day meeting. That's just too much.

The other thing is that once CME was mandated, then all kinds of people were starting to putting on CME programs. They were worthless, many of them. I went to one that was put on by the University of Southern California, Department of Anesthesia, and it was just the good old boys talking about the good old times. I didn't learn anything. It was an absolute waste of my time and money. I'll never go to a USC program because of this. You end up picking and choosing, but the one in Arizona is excellent. They have visiting professors from all over the country down there. I look at the faculty and say, "OK. I know what his lectures are about; I've heard it ten times, and I'm not interested in that. And this is neurosurgery; we don't do neurosurgery. There's not enough in this program to make it worthwhile for me to go." Even though I can get credit for listening to an hour's worth of discussion of neurosurgery anesthesia, we don't do that here in Carson. But I still get credit for it.

That's the flip side of the thing, too. I can go to a five-day session on pediatrics. I don't do anything with kids, but I can still get credit for it in terms of meeting requirements of the law. This is why that requirement is silly. There's no way for it to effectively accomplish what it was meant to accomplish. All it does is create a paper trail that satisfies the requirement that there be a paper trail. But in terms of assuring that a physician is maintaining some level of competence by going to these things, it has no way of creating that assurance.

How can you get it? How can you create that assurance?

You can't.

Do you depend then on a physician's integrity that he will keep abreast of things?

Well, even with the current program with the CME you're dependent upon the physician's integrity to pick the programs that are worthwhile for himself, to make sure he goes and doesn't waste his time and money, and most physicians do that. We discussed this problem at length when I was on the Board. Physicians all over have discussed this problem. How do you adequately assure that a physician is maintaining his skills? We had a physician here in town who attended every single lecture; he took copious notes; his notes, when he was finished, were more than everyone else's in the room put together, including the speaker. But he learned nothing from it. He was an older physician, and he was trying to demonstrate to everyone else that he was making an effort to stay up. But he didn't have the basis for even assimilating the knowledge. And so he had fallen further and further behind, and his practice changed

necessarily to reflect that. His hospital privileges changed to reflect that.

Working in the hospital environment, there's a lot of control, and you have so many people watching you. People talk. I had one surgeon say to me, "Well, you know so-and-so, when he does a case, he's always used this sort of drug. I never see you using that."

And I said, "Oh, yes, it's a new drug, and it has these advantages, but these are the disadvantages." The last disadvantage is that I have to learn a new drug to use it. You add up all the disadvantages versus the advantages, and I'm not interested; it doesn't provide me with enough advantage to make a change.

We've had a lot of new drugs that have appeared on the market, and some of them are causing problems. It takes million of uses and lots and lots of exposure in the environment before these problems show up, because they couldn't really duplicate the clinical use of them in the laboratory. Small clinical trials didn't necessarily reveal all of the problems. But you put them into practice and suddenly, or maybe not so suddenly, things happen. There was a new drug that we use a lot of, and it came out with the manufacturer's recommendations for dose. Anesthesiologists were the ones that were primarily using the drug. Within two weeks all of us were talking, "Have you tried this drug?"

"Yeah."

"You know, this drug's a whole lot more potent than it would indicate. I mean the dose that the manufacturer recommends is way too high."

I said, "I know, I dilute it by five and give only one fifth of the recommended dose." In six months the manufacturer had repackaged it because every anesthesiologist in the country discovered that. So those are the kinds of real world things that happen. And

that's education. This is real world learning, and this is the best kind of learning.

The other thing is that if I start making mistakes, I've got five people in the operating room watching me. If I'm in private practice out in my little office and I start making mistakes, there's nobody watching me. So working in the hospital environment is a real good control for the public interests. The Board of Medical Examiners licenses this person, but the clinical privileges in the hospital are under far closer scrutiny than the Board could ever do. You've got surgeons watching surgeons; you've got surgeons watching anesthesiologists; you've got anesthesiologists watching surgeons; you've got nurses involved; you've got all kinds of people.

We have incredible tracking of incidents. Anything can happen. I had a patient spend ten minutes longer than what we consider reasonable in the recovery room. I've got to explain that to a meeting. Physicians are being held accountable by their peers far more now than they were fifteen years ago. I mean it's just a totally different world. So this is where the public interest is really being protected: in the hospital environment. For a physician that's outside of that, there's no way, no practical way, of dealing with it that I see at this point. As I say, CME is a feel-good-thing that accomplishes little if anything.

One issue that has come up with the Board is centralization of licensing boards or a regulatory boards.

Well, there a lot of states that do that, and we've tried very hard not to allow that to happen here. There was a lot of talk about it a couple of years ago because the medical

board was accumulating considerable sums in their bank accounts. The medical board, with almost two thousand physicians licensed in the state, has a lot of financial resources. Then the state's looking around, and here they see this board with all this money. And they say, "Well, we ought to have umbrella boards." There are all kinds of activities with licenses involved and boards involved, but they don't have many members. They can't afford to staff; they can't afford to investigate; they can't afford this and that. We feel that it probably would be appropriate for the state to create an umbrella agency for those boards that can't manage their own affairs. But boards with enough members or licensees that generate enough money for them to provide adequate supervision — I feel they should be left alone. But I don't see why the physicians as a group should have to provide office space, secretarial help, and investigators for the board of homeopathy or naturopathy or whatever other board there might be.

It boils down to money, and so one of the things that the Board of Medical Examiners did was reduce the fees when we started getting too much money because that becomes an attraction for sharks. It has nothing to do with better services or anything else; the fundamental issue is money. They view the physicians as having money, so one of the things they can do is charge large fees for physicians and have them support the other boards. Our feeling is that if the state of Nevada wishes to license those other boards and patrol them, then that's incumbent upon the state to do that. It's not a physician's obligation. We take care of our own problems.

The issue of the HIV positive physician became a public concern when you were on the Board.

We talked about that a lot. What was the Board's responsibility? Should we adopt a policy; should we not adopt a policy? All of these various issues were discussed at length, inexhaustibly, ad nauseam. It went on and on and on and on. We gave it a fair shake in terms of discussion.

The evidence right now is such that we don't really know of any case where a patient has gotten HIV from a health care provider. In the one case of a dentist in Florida, it is now turning out that everyone that got HIV had other life style considerations which would have made them highly likely to be HIV for other reasons than having visited that dentist. That's starting to come into question, because the feeling was that he would have had to deliberately do something to inoculate these patients with HIV. HIV is a relatively difficult disease to catch. The virus is not very hardy. It takes a lot of what we call inoculum — the mass of tissue, fluid, or whatever containing the virus — to cause an infection. When we were first getting educated on it, we had a physician from San Francisco, and he was saying that the gays in San Francisco that had AIDS had between twenty and fifty thousand sexual contacts.

Fifty thousand?

Yes. That's a lot, yes. The details of how they went about this is sickening, but they did it nonetheless. So that kind of gives you something on that end. With a needle stick, for instance, if you got a needle that might have been contaminated, you're far more likely to have hepatitis than HIV. Hepatitis is still a main concern, with blood transfusions and the rest of that, for the one that handles the blood.

In terms of protecting the public, the Board had to consider: what were we protecting the public from? There are no

incidents of infection from physician to patient, so how are we going to make it lower than that? If we adopt a policy, what's the point of the policy if we make the physician wear a sign that says, "I am HIV positive"? What does that do for the public? It scares them! But does it do any good? Not that we could see. It's a social problem in the sense of public fear, but in terms of being a medical problem, it hasn't been demonstrated that it is. I think if you ask anyone, "If your physician was HIV positive, would you want to know?" They'd probably say, "Yes." And you ask, "Why?" Well, they don't have the knowledge to give you an answer that is scientifically reasonable. The why is obvious: "I don't want to catch it. Good lord, who would want to be around somebody like that?" The response would be emotional. The Board felt that did not serve the public to have them react emotionally to an issue when they didn't need to.

Over the years the Board has confronted the issue of alternative medical practice.

When I was president of the State Medical Association, and I was back in Chicago at the meetings there, people would come up and see my tags from Nevada. They said, "Your state flag should be a duck."

And I said, "Why?"

They said, "Because you're the home of the quacks!"

Nevada has the homeopaths, the naturopaths, the midwives; we've got Laetrile; we've got Gerovital that they licensed. It is a freewheeling state. Somebody wants it? We make it OK. The state was known as a place for quack medicine. And part of it was that once you got your license, you could almost do anything you wanted, because the Board didn't have the tools it needed to properly

deal with physicians who were working on the other side of whatever margin they should have been working on. The history of the Board is replete with cases where they tried to go after physicians and failed. So that's part of why the Board went to the legislature and got the axe strengthened in 1985. Subsequently, it tightened up in other places to get around this.

But in your examination Nevada made you retake the microbiology portion. Is there a contradiction here?

Oh, no. All I was saying is that they had their authorities in certain places, and where they did, they exercised them, that's all. That happened to be one place where they were fairly much on top of what was going on. In other places they didn't have the tools that they needed to be tight.

Does Nevada still have a reputation as "home of the quacks"?

I don't think so, not now that the license laws are toughened up. Other states are now using Nevada as a model for their licensing. I don't know if it still is, but with the change in the law, Nevada was probably the toughest state in the nation to get a license. So Nevada has done a total one eighty on that. And getting a Nevada license is a big deal.

It all comes back to the Board. Its function is to license physicians, and to protect the people of Nevada. And it does that.

Medicine has changed a great deal over the course of your career. If you had it do over again, would you still go into medicine?

I have wondered what my life would have been like if I had stayed with computers instead

of going into medicine. As to the present, I find the current climate for practicing medicine onerous. However, I can imagine no greater job satisfaction than that which I have when a patient entrusts me to do what I do to them in the operating room. In the operating room, there is still a surgeon, assistant, OR nurses, the patient and me. I can think of no greater privilege than to be able to be there providing patient care.

KENNETH TURNER, M.D.

Dr. Kenneth Turner was born in Tillamook, Oregon, in 1924. His family farmed near Portland, and he graduated from high school in Gresham, Oregon, in 1941.

He attended Walla Walla College for a semester before going into the army in 1943, where he served with the Seventeenth Airborne Division in France. After WWII, he finished his undergraduate work at Walla Walla in 1948 and received a medical degree from Loma Linda University in 1952. Dr. Turner did an internship at Harris Hospital in Fort Worth, Texas, from 1952-1953; then practiced in Bellflower, California, as a general practitioner for one year. He returned to school to specialize and served obstetrics residencies at Kern General Hospital in Bakersfield, California; Harris Hospital in Fort Worth; and Gorgas Hospital in the Panama Canal Zone.

He practiced in Truckee, California, for two years before relocating to Las Vegas in 1960, where he has practiced since.

Dr. Turner has been active in medical politics as chief of staff at both Southern Nevada Memorial Hospital and Women's Hospital. He

was president of the Clark County Medical Society in 1968 and served as an alternate delegate to the American Medical Association from 1968-1972. He was a member of the Nevada State Board of Medical Examiners from 1966-1971.

Dr. Kenneth Turner: I was born May 14, 1924, in Tillamook, Oregon. My father was a rancher, farmer, and I lived there until I was two. At that time my father's relatives were involved in the Tillamook cheese industry. We then moved to Pleasant Valley, which is about fifteen miles outside of Portland, Oregon. We lived there on a ranch, or a farm, and I went to elementary school in Pleasant Valley. It was a small school, probably eighty or ninety students.

We had a hundred and twenty-five acres of really lush farmland, and my dad extended this by buying some other land about 1928. And then the crash came. You couldn't even give away milk. We had something like fifteen hundred apple trees, and you couldn't give away the apples, so as a consequence we lost

the farm. We continued to live in the Pleasant Valley area, and my dad became a real estate broker but houses weren't selling that well either at that time, [laughter] but we existed.

In his early life my father had also been a logger, and he did a variety of things. He built houses, he formed a logging company; and all the way through my high school summer vacations and college vacations and medical school vacations for the first couple of years, I worked for his logging company. We cut telephone poles. I loved it; it was great exercise.

My father died in 1952. I had four sisters, four older sisters, three of whom are living and still live in the Portland area. My mother died three years ago at the age of ninety-nine.

About the time I entered high school, we moved closer to Portland, and I graduated from Gresham High School in 1941. I worked right after high school for a year, and then I went to Walla Walla College, Walla Walla, Washington, which is a Seventh-Day Adventist School. My mother had been an Adventist. I studied pre-med there in 1942.

Were you raised as an Adventist?

Well, my father wasn't an Adventist, but I went to Adventist church. I didn't go to the Adventist schools until I went to college. I am not a practicing Adventist now. I do follow some of their teachings. I'm a vegetarian, but I haven't been all my life. But I do this mainly for health reasons. I do feel a lot better than I used to feel, better than when I ate red meat.

I really enjoyed going to a smaller college; we had about a thousand students, and so we knew everybody, and you could be active in anything you wanted to be. I enjoyed going to Loma Linda, because it just seemed to be a good place to go to school.

Was it also a Seventh-Day Adventist school?

Yes. It was a Seventh-Day Adventist medical school — more notable now as the first place where a baboon heart transplant was performed by Dr. Bailey. They have also have a unique radiotherapy department there. It's the only one in the whole world. Paul Asinger went there recently for treatment of his cancer of the bone. People come from all over the world to go there for radiation treatments, so it's a well-respected university.

You said you had four sisters, and you lived on a ranch. Did your mother work in the home?

She stayed home. My mother had graduated, interestingly enough, from Walla Walla College and was a teacher when she met my father. This certainly helped me, that and having four older sisters, because we lived on a ranch. My mother, having been a schoolteacher, had a lot of books. My older sisters would come home from school, and then we would play school. So I could read when I was age three.

I developed a real interest in history because I loved history books. As a matter of fact, when I went to college the first time, I wanted to be a history major. My advisor was a history professor who was really unhappy, very disgruntled. I was a straight A student, and he said, "With your grades, you know, they really need doctors." [laughter] And so I thought, "Well, that doesn't sound bad." [laughter] I transferred from a history major to a chemistry and biology major.

So education was emphasized at home?

Yes. My father was on the school board, and so education was a really important thing in my life. As a result of my sisters and my mother having taught me, I skipped the second grade. I wouldn't advise this for anybody,

because my father was a consummate athlete; he'd played shortstop for professional baseball leagues, and he was a boxer. He was small; he was only five-foot-eight and a hundred and thirty-five pounds, but he was a consummate athlete. To me he was my hero!

I wanted so badly to be an athlete, but I was really tiny. All the way through high school I was small; probably in my senior year I was about five feet and weighed one hundred pounds. I went out for the sports team but just wasn't big enough. In retrospect I would say part of it was the fact that I skipped a grade and I was a late developer. It really inhibited my social life all the way through high school because I was smaller than any girl in school. [laughter] I liked girls, but I was their friend, you know. I was a year younger, and then I was so small. I didn't start growing until the latter part of my senior year. Now I'm six-foot-one-and-a-half.

I thought I was going to be a jockey. You know, we lived on the ranch, and I could ride horses well. I was one hundred pounds and I didn't think I was going to be any bigger. So I thought, well, maybe being a jockey wouldn't be all that bad. [laughter] Then I grew.

You mentioned that your family lost the farm.

My family lost the farm; it was a foreclosure by the bank when we just couldn't sell any of the farm products.

If people remember the Great Depression, it seems to be an experience that had a tremendous impact on them.

Well, there was an impact, but I don't look back on it as really bad all the time. It really drew the family together because, living on this type of farm, we had neighbors, but it was a little more isolation than you would

have in the city. We did a lot of things on our own. Every Christmas my sisters and I would put on Christmas plays, and all the neighbors would come for it. It was a lot of fun. [laughter] And going to a really small grade school was kind of nice, too. With two grades in each room there was a sense of community that you don't get in large schools. I kind of feel sorry for these kids that go to these schools that have two or three thousand kids or a thousand kids, because you can't really be important in the school.

What about limiting your education possibilities because of its size?

Well, I don't think so. In the era when I grew up you probably had more individual attention; we had something like fourteen or fifteen students in my grade and probably that many in the next grades. So the teacher would teach the lessons to one grade, then the other grade. I think it helped when I was, say, in the third grade, fifth grade and seventh grade, because you were part of the grade ahead of you. You could learn. I was a straight A student, so I could really do my work really fast. In a sense maybe the next year was really easy, because you had already gone through it.

There were a lot of activities. We had plays, and in those days the farm communities had what was called the Grange Hall. Actually it was a center for entertainment for the whole small area. We had one little store and a gas station. That was about it, but they would have all kinds of community entertainment at the Grange. Every year the students would have to learn a poem. I can still recite some of these poems. Like:

You can talk a gin and beer when you're quartered safe out here

and you've set the penny fight and
aldershot it

But when it comes to slaughter, you will
do your work on water

and you'll lick the bloomin' boots of 'em
that's got it.

That's from Gunga Din, Kipling. And
let's see:

Have you heard of the wonderful one-
hoss shay

that was built in such a wonderful way
that it lasted a hundred days to a day.

By Oliver Wendell Holmes. I can still
remember fragments of these poems.
[laughter] So, actually, I don't look back on
it as a period of deprivation.

The family worked hard. I had sworn
when I was a kid that when I got off that farm
I would never ever even visit a farm again!
You worked twelve hours in the summers
raking hay and hoeing corn, and all that kind
of stuff. Picking strawberries was my worst
experience.

Why did you hate to pick strawberries?

Because I was kind of a lazy little kid and
you had to get down on your hands and knees
in the burning hot sun and just go on down
the row. I hated it!

Row after row . . .

Row after row. But looking back on it, it
was not a bad life in spite of the hard work.
My father was able to make enough money to
buy us food and everything. I was fairly happy.

I had other jobs, though. When we
moved near Portland, we were really close to
Glendoveer Golf Course, which is a thirty-six-

hole public golf course. When I was twelve, I
rode my bicycle there and applied as a caddie.
I really loved golf! We could play every day of
the week except the weekend; they furnished
the clubs and everything. It was a lot of fun.

The other thing that I learned when I was
a caddie was how to be a gambling hustler.
There were about eight caddies, and between
each job caddying, there was a constant
poker game and blackjack game. I had never
gambled, having come from fairly religious
background, but the best way to learn how
to gamble successfully is to play with guys
that take your money. [laughter] My mother
never knew this.

You were hustling when you were twelve?

Yes. You always played for a nickel a hole
when you played golf, and that was a lot of
money in the late 1930s. You tried every little
edge.

*What do you mean you played for a nickel a
hole?*

Well, the caddies ranged from age sixty to
my age, which was twelve. There was just this
atmosphere of gambling in the caddie shack.
When you went out to play, you played for a
nickel a hole, and you either learned real fast
or you lost.

So it's the caddies that are playing.

Yes. One summer there four of us who
caddied for four very wealthy oil wives that
came up every summer. We would bet on the
lady that we were caddying for a nickel a hole.
I remember once there was a through par
hole, and they couldn't see the can from the
tee. So we laid around on the green waiting
for them to shoot, and my lady hit a ball that

was fairly close to the hole. I sneaked across the green and put it in the hole. A hole in one in those days was really a major thing; they got all kinds of prizes from the companies and everything. So we started screaming, and this woman, if she's still living, believes that she had a hole in one.

Mischievous, right?

Yeah.

How old were you when you did this?

Oh, I was probably thirteen or fourteen. It was a lot of fun, though. I've always had a lot of fun in my life.

Do you still play golf?

You know, you see the little copper thing here on my wrist? [Pointing to a copper bracelet] About two years ago I was on the golf course, and I fell over a rope, and I came down on my wrist and have tendinitis. Just last Sunday I was at Nevada Bob's, the golf store. I was telling the pro, a friend of mine, about it, and he gave me this copper band to put on my wrist. [laughter]

Is this within traditional medical practice?

It's holistic, I think. [laughter] It's supposed to cure tendinitis, and I'm going to give it a shot.

When I was fifteen and sixteen, I played in the Oregon State Junior Tournament. I wasn't really good, because I won the tenth flight and the next year I won the eighth flight. But I was going up! [laughter] In fact, at that time, like all kids, you have these weird dreams, and I wanted to be a golf professional. The golf pro at the club had taken me in hand and got me

some clubs and was teaching me golf and teaching me how to repair clubs and things like that. But my mother held out for me going to college. [laughter]

Did any of your sisters go to college?

Three of my sisters went to college, and one of them got married before she went to college. One sister is a nurse, and they all married OK. One of them is married to a man that was the head of the physics and math department at Molalla High School; one married a contractor; one married a lab technician.

You said you worked after high school for a year.

I worked in an army hospital — this was in Vancouver, Washington — as an orderly.

How did that come about?

Well, you know, it was still at the end of the Depression, and I didn't have a lot of money. I was still kind of under the influence of my mother, who wanted me to go to Walla Walla College. I had been accepted on a scholarship to Oregon State University. But in those days I think family and religious influences were strong. There were fears that you might be led astray, and my sisters were pretty devout Adventists. So I had all this family influence away from Oregon. Even at that time I wasn't a terribly religious person; I was more interested in sports and everything, but I turned down the scholarship.

I went to a radio school that summer in Portland. We made radios and radio equipment for the police department and for the army, and learned the Morse Code. That summer I worked, I applied at the army

hospital in Vancouver, Washington, which is just across the Columbia River from Portland, so a friend and I were orderlies there for a year.

Was that the influence that made you decide to be a physician?

Well, yes. I liked the nine months or so that I worked in the army hospital. I still had this vision of a history professor, though. Wearing a tweed coat, with a pipe, although I've never smoked; but you have this image in your mind of a tweed coat and a pipe and the professorial type.

You were in Vancouver for a year; then you went to Walla Walla for a year?

I worked my way through Walla Walla the first year because I worked two jobs. I washed pots and pans, and I collected laundry and worked in the laundry. It was hard work, but most times you can enjoy work. You can tell I'm a social person; I enjoyed working for the laundry because only girls worked in the laundry. I was the only guy. [laughter] Also washing pots and pans; everybody else was girls. Since I had such a bereft experience, social experience in high school, being so small, this was really something. I think God repays you sometimes.

I was at Walla Walla for one semester, then drafted into the army in February 1943. I was sent to Camp Barkley, Texas, for basic training, and then I was in the medical corps, maybe because I was pre-med. We went to England, and I eventually ended up with the Seventeenth Airborne Division in France. They needed a medical aid man in the infantry, so I was sent and eventually joined the Airborne Infantry as a glider and medical aid man.

In those days, I don't think they do this now, but on an invasion the Airborne Infantry is composed of two regiments of paratroopers and one regiment of gliders. The gliders, two of them, were towed behind C-47s. When they get over the landing area, they are cut loose and they land. They carried not only soldiers, but Jeeps and equipment that the infantry needs. In our glider we had a big Jeep trailer full of supplies. The glider that just took men in would hold a pilot and copilot and twenty-one soldiers.

And so essentially is the glider functioning as a way of getting the men down from the huge transports?

Yes. Naturally, paratroopers can't bring in Jeeps and trailers and supplies. So gliders essentially not only brought in supporting troops, but brought in supplies. You've seen these balsa wood model planes? Well, that's what gliders are made out of. [laughter]

You would think that the heavy Jeeps would just fall out!

Yeah, it's so light and made of such flimsy material. This is a little bit gross, but we had this big Jeep trailer, and we started out from western France, west of Paris. It was a three-hour flight. I don't know if you've been in a light plane or anything, where it's like this? [gestures with hand in up and down motion] The wind was blowing hard, and it was just like that all the way. Some of the enlisted men in the back of the glider became very sick and vomited in their helmets. We had the air sick bag up front, and it was slippery because I had vomited on it. The guy that was next to me was handing it to me and dropped it, and it spilled all over me. I have never been so sick in all my life! I thought, "Isn't this going to ever end?"

It might have been fate, although I don't know if I believe in fate, but I was the lowest-ranking enlisted man. I was always a private; I was never promoted because I had a lot of fun. I never took anything seriously. As we were to get on the glider, I, being a private and the lowest ranking, was supposed to be in back of the glider. But my paratrooper boot became untied, and I knelt down to tie my paratrooper boot, and so the other four enlisted men got on first. I was sitting next to the captain.

When they cut us loose, we found out that all the army recon missions before the flight were wrong. They said there was nothing there, no opposition. But the Germans had two SS Divisions and a couple of other divisions there, so they were really a mess for us. As we landed, we were starting to get machine gun bullets through the wings. When we landed, the doctor was next to the door, and it's about five or six feet up from the land. He just dove out, and I dove out second. As I looked around, the third guy was in the door, and his face disappeared as he was hit. I crawled away from the immediate area, but fortunately I guess the glider was between us and the people who were sending stuff in. They threw in three other mortar shells. We lay out for three hours under enemy fire. I thought I was the only one there because everybody was quiet. There was a glider in the next field that had evidently had a Jeep in it, and it was hit just as it landed, and before the wheels came to a stop, it was ashes; everything was just ashes.

A German ambulance came to the next field and was picking up people. I thought I was alone, and I didn't know whether to wave or what, you know. Then I decided to just lay there. The pilot was just in front of me, and finally, after about three hours, I whispered, "Captain, Captain," and he moved his foot, so I knew I wasn't alone. It turned out that

the doctor and the copilot and I were living; everybody else was killed. If I hadn't stopped to tie my shoe, I wouldn't have made it. So I guess it's fate or whatever you want to call it. [laughter] I know it wasn't karma because I haven't lived my life that well. [laughter]

Anyway, we stayed in the middle of the fighting for twenty-four hours, and then they brought one of those amphibian vessels and took us to a hospital across the Rhine on the Holland side. I was operated on there in three or four days.

You were wounded when you were landing?

Yes, twenty-six times. I had my first operation in Holland in probably a MASH-like unit. Then we were evacuated to Liege, Belgium, and that's when Dr. Maclean operated on me. We went to Bristol, England, and I was operated on again, and then we were evacuated to the United States.

What prompted or what made you remember Dr. Maclean specifically?

I used to have — I don't know if it is still that good — but the type of memory that can recall little trivial things like names. Well, when I practiced in Truckee, I shared offices with Dr. Larry Nelson. He just died last year in February, but he went from Truckee and practiced in Sparks. He was a close friend of Ken Maclean, and so Ken did all our general surgery; we would send them to Reno. So I knew him then, but I had no clue then that he was the one that operated on me until I became a member of the State Board of Medical Examiners. We were talking about war stories, and he told me that he was a major in Liege, Belgium, and then I remembered.

He is one of my heroes. He and Dr. Les Moren are my two heroes in this state.

It seemed like both of them weren't in the business for money, the business of medicine to make money. They are really good doctors.

I was sent back to the United States and a variety of hospitals, and then I was discharged in October of 1945 and re-entered Walla Walla College in probably January of 1946. When I was discharged, they said, "Who do you want to handle your claims against the government as far as wounds?"

I didn't even know what they meant, and so I said, "Oh." They gave me a choice of the Red Cross, American Legion, Veterans of Foreign Wars, so just off the top of my head, I said, "American Legion." They had the GI Bill, but I wanted to save it until I got into medical school. I was in school about three months, and I got a letter from the Veterans Administration Hospital in Portland. They wanted me to come down for a physical. I didn't know what was going on, but I went down there for the physical; then I went back to school. About three months later they called and said that they had ruled that I was 50 percent disabled. Financially it was really great, because if you're a disabled veteran with war-related injuries, they will pay the tuition all the way through medical school, through internship. They would pay all the tuition, the books and everything, plus a pension. So financially this was really a great thing for me.

Did they pay undergraduate, too?

Yes, they paid everything, graduate, undergraduate, all the way through internship. Walla Walla College has a really good situation in that you could be the son of Howard Hughes, but you still have to work. Part of the plan is that you have to have a job there. And again I washed pots and pans for years; then I was a busboy, which was really

the prime job there. [laughter] It wasn't hard work, and the people that were really cool on the campus were busboys. [laughter]

Still making up for high school?

Yeah. I had a good time.

So you did undergraduate at Walla Walla, and you graduated with a B.S.

B.S., yes. My major was chemistry and my minor, biology. At that time, if you were taking pre-med, they didn't give you such a broad education. Now you can take almost anything you want, but then medical schools demanded you have so many science requirements. It almost necessitated that you take a chemistry or biology major.

And then you went on to Loma Linda? Was the fact that it was an Adventist university part of your decision to go there?

Yes. You know, Walla Walla was kind of rigid in the requirements. I mean they had a curfew every night, and that didn't bother me at all. But when you got down to Loma Linda, there were no restrictions. They thought you were mature. I was twenty-four, so I was mature. I lived on campus, and we had a great time.

This was before you were married?

Yes, for two years.

What about medical school?

Loma Linda at that time was a very rural, countrified area. It was in the center between San Bernardino, Riverside, and Redlands. There were hundreds of orange groves. It was

basic science; medical education was much different than it is now in that essentially the first two years were basic science. They had a hospital there, and we did have some patient contact in the second year, but not a lot. At that time Loma Linda was at two campuses. The first two years were basic sciences at Loma Linda; the last two years were L.A. County Hospital for the third year and then the White Memorial Hospital for the final year.

You had been in an urban setting in Portland, but was working in L.A. County an eye-opener?

Portland then I wouldn't say was urban. They had downtown, but everything else was suburbs. And it was the best of all urban life. L.A. was a new experience. It was really a new experience, because it was one of probably the top three or four hospitals in the country as far as beds and activity. You suddenly were thrust into this new environment. We lived just off campus, off of the White Memorial Hospital, which was about a mile away from the county hospital. We lived in Boyle Heights in East L.A. Right now it's really a dangerous area as far as barrios, the gangs, and things like that. Even then it was a lot different than a lot of urban areas. It was a long time ago, but even then it was a little different. But I enjoyed the County Hospital. It really was so much different than basic science because you were seeing patients, and there was just a new era.

Were you also in the classroom?

Yes, we had didactic lectures every day. We had a hundred in our class, and it was split up in three groups, and you rotated with one group. You rotated through the different services. It was alphabetically, so from eses and on, I was with them for two years. [laughter]

How long were your rotations?

I think the longest rotation probably was in internal medicine and the various subspecialties. OB was about six weeks in the junior year, and then we had more in the senior year. Pediatrics was probably, I don't know, a month maybe or so, and just various subspecialties, mostly in the senior year. I loved subspecialties. We would attend some of the clinics at county hospitals, and we would do histories and physicals and admissions on the service we were on. Draw the blood, do the scut work, but it was fun because it was new, and I was pretty relaxed on everything.

Because of my background I did well in my I.Q. test. I have a theory that you don't agonize over a question, use your first impression; and in that way, in an I.Q. test, you can finish a lot more questions than if you think about everything. I did the same thing in medical school. I always went with my first impressions on my tests. In four years of medical school I was always the first one done in every test we ever took. They used to give me a standing ovation when I got up! There are a lot of people that would have gastrointestinal upsets before a test. I always just went with first impressions, and I would just go through it, and I'd be done. I still think that's better than agonizing over every answer and going back and changing them.

But I had a lot of fun; everything can't be just deadly serious. At Loma Linda, also, we had athletic stuff. We had volleyball teams, we played football, we had swimming, we had tennis, we had golf — there were a lot of things to do.

I got married after my sophomore year. My wife was the daughter of the head dietitian at Loma Linda Medical School. To this day I don't think she has ever tasted any kind of meat, fish or chicken. But she was really

pretty and a freshman in college at La Sierra College, which was nearby. I met her, and we got married the following October. She spent the summer with me in Portland in my folks' house. When we were driving back to Loma Linda, we got married in Carson City by a justice of the peace. [laughter] Nobody knew about it until she got pregnant. [laughter] Anyway, she went to college the first year we were married, and so I lived with some of my classmates in a house right next to White Memorial. We didn't actually live together until the next summer.

When did you decide on your specialty?

Well, I'm not much into psychoanalysis or anything, but having grown up on kind of an isolated farm with four sisters I was probably more comfortable, really comfortable around women. I just seemed the obstetric type — I still like obstetrics better than gynecology. I really love obstetrics. I think that maybe I decided when I was a junior and we were rotating at County Hospital. It was a zoo, because they had so many deliveries that the medical students could deliver a lot. I think I delivered thirty or forty babies as a third-year medical student just because of the magnitude of deliveries there; they were letting everybody deliver. And so I really liked it.

There are very few specialties in medicine that really attracted me. Amazingly enough, I was down to two specialties, and they were so far separated — one was dermatology, and one was obstetrics and gynecology. I was in a group, kind of like a fraternity, and our sponsor was a really well-known dermatologist from Beverly Hills. He was president of the California Medical Society, and everything and he asked me if I would take a dermatology residency, and then I could join him. But I think my interest was

probably his influence, too, you know, because I admired him and he was successful. Anyway, I'm glad I'm an obstetrician.

By your junior year you had decided, and you went to Texas for an internship?

Yes. I had known some people from Fort Worth, and my best friend in pre-med was Joe Pate from Lubbock, Texas. His father had cotton farms and stuff, and he didn't make medical school, but it was a good thing for him because he became worth probably ten or fifteen million now with his various investments. But I had gone down to see him, and then my best friend in medical school had externed at Harris Hospital, and he came back with glowing reports.

Externship is where you work at a hospital, not as an intern, but you work up histories and physicals about like when you are in medical school. He did that at Harris Hospital one summer. He really liked it, and so I decided to go there. I'd been in Texas in basic training in the army, and I really liked Texas. So I thought I'd go down there.

I was there from 1952 to 1953. It was a good hospital. Actually, it was a Methodist hospital; it was the biggest hospital then in Fort Worth, and they had a large clinic service which was good.

There was so much difference when I was there between Fort Worth and Dallas. Dallas was even then a very cosmopolitan city, and Fort Worth was cow town. I wore cowboy boots, and we'd go down to the bank in scrub suits, and nobody cared. It was just really a relaxed environment. I liked it. We had our second daughter in Fort Worth when I was an intern.

I did my residency at Kern General Hospital in Bakersfield, California. My wife was from California, and she wanted to come

back to California. It was a good, active hospital. I mean, I delivered six hundred babies the first year I was there. The training was good, but then after a year, again I was in financial straits, and my wife was pregnant again.

I joined this large group in Bellflower; it's near Long Beach. But I soon hated general practice, because as the young kid in the group, I was on call every other night and every other weekend. And I did all the house calls. I hated it! [laughter] I talked to some friends of mine back in Fort Worth, and they said, "Why don't you come back here for your second year?" And so I did. I had been accepted at Emory University in Atlanta, but they only paid one hundred dollars a month, and so I went to Fort Worth.

I always have had a kind of a wanderlust, and I checked out the residency in the Panama Canal Zone. We went down there in July of 1956. It was a good residency, and it paid six hundred and fifty dollars for senior resident. It was hazard pay; it wasn't really hazardous, and we loved it down there. My wife was an actress, and she became involved in the theater guild, and she starred in *Bus Stop* and *Picnic* and a bunch of things; it was really professional. Several of the people went on to really successful acting careers. We had a full-time maid for thirty dollars a month. We had our fourth baby before we got there. I loved it because it was just really relaxed.

The temperature in the Canal Zone was always eighty-nine to ninety. Half of the year was the rainy season, where it was so wet I couldn't see the end of this room, it would rain so hard. During the dry season it was really dry. We had a family of marmosets right outside of our duplex and a big avocado tree. The avocados, they were that big. [gestures to show about six inches] There were probably thirty marmosets. They

don't have windows in the Canal Zone; they just have screens. Because that's how you get the air conditioning. So one of the little baby marmosets, the mother was trying to teach it independence. The baby was always on her back, so she shook it off. And it was crying and crying, so the maid went out and brought it inside the house. And we had thirty marmosets on our screen crying, just like people, until we took it back out. [laughter]

How big was the marmoset?

About like this. [gestures so show six to eight inches] Like a big baby with a long tail. There was an animal called a kinkajou. It's kind of a small bear-like animal. I remember coming home one night, and the kids were all excited because the neighbors had a pet kinkajou. I had never seen one before in my life. It had come and opened our screen door and was in the kitchen.

It was a fascinating place to live. Historically it was good, too, because of Balboa and Morgan the Pirate. It was a lot of fun, and socially it was a party every night if you wanted to do it. And you don't wear ties; you just wear a white kind of a lace; it's cotton but with little holes in it, and that's formal. Everybody was nice, and the benefits were great. You got two months vacation every year.

Were you in an army hospital?

No, this was a civil service hospital, but we took care of all the army and navy and air force dependents, plus they had about sixty-five thousand Americans and Panamanians who worked at the canal.

There was a little discrimination. We had the Silver Service and the Gold Service as far as deliveries. The Panamanians were the

Silver Service, and the interns delivered them; but we would go down and instruct interns. The Gold Service was for the Americans, and the residents delivered them. [laughter] You know, I didn't make the rules. [laughter] They were actually getting good care because interns delivered, but we were right there on every delivery. And they would come up and help us on the Americans. We'd do the deliveries, but the interns would help us.

But it was a lot of fun, and I enjoyed it, and my wife enjoyed it, naturally, and the kids loved it. They had a lot of beaches, and every weekend we weren't on, we'd go to the beach. I loved it down there.

Could you have stayed?

I could have stayed, but I was really anxious to try and get my feet wet in private practice. In fact, the air force came to me in my residency there; at that time they needed obstetricians in the air force. They offered me the rank of major, plus a bonus for signing, plus my first post would have been on the Riviera for two years. It was kind of a tempting . . . a lot of times I wish I had done that. [laughter]

Why didn't you?

Because I was just so anxious to try private practice.

Didn't your earlier experiences in private practice sour you?

No, because I was doing things I didn't like. You know, for example, in that group they had a surgery in the office. They did tonsils, and it was my job as a young guy to give anesthesia, and I hated it. I just absolutely hated it. The whole experience was bad for me

down there. But I liked people; I really love people. It wasn't seeing people; it was just what I had to do there.

When I left the Canal Zone in 1957, we were having a recession. When I was in the last year of residency, I applied for staff privileges and was on the staff at Encino Hospital. I had loved Encino when I was in medical school. It was a lovely community with tree-lined streets and little boutiques. There wasn't an obstetrician there, and they had just built a hospital. But when I came back, we were really into a bad recession for about a year. I needed to borrow money to go into practice, but I couldn't borrow any money.

My wife's sister was married to a pathologist in Loma Linda, and his best friend was Larry Nelson, in Truckee. So he talked to him, and he said, "Hey, have him come; I think he could be busy enough delivering babies." Well, as it turned out I was only delivering about seven babies a month, and I started to do all this emergency room work and stuff. I loved the area and I still love it.

Tahoe-Forest Hospital was about a twenty-one-bed hospital, and Larry was really busy. When he was out of town I would have to cover for him. Sometimes eighteen patients of the twenty-one would be his. [laughter]

One interesting thing was the Winter Olympics, which was in 1960 at Squaw Valley. I left in October 1959, but they had the prelude to the Olympics, which were the Pan American Games at Squaw Valley in 1959. The same Olympic Teams that were going to be at the Winter Olympics were there from every country. And Larry Nelson was the medical director for the Games. He had to have emergency surgery and was out of practice for several weeks, so suddenly, as an obstetrician, I was medical director of the Pan American Games.

We had a multitude of injuries, a fracture on the skier from Japan and one from Peru. We had a very interesting patient; he was a one-armed ice skater from Russia. He was an engineer as well as a championship skater, and he had chronic pyelonephritis.

When I became medical director, I would bring specialists from Reno to come in and see the patients every day. It saved my life, because these were the Olympians, and if I'd screwed up one treatment, it would have been an international incident, I guess. This was during the Cold War.

Anyway, Peter Rowe was an internist from Reno, and he would come over every day. The Russian skater had what the Russians called a felder. That's a person with two years medical school, and they were general practitioners. The felder for the team was a lady. When she wasn't there the skater could speak English; he was a nice guy, and we could talk. But when she was there, it was like he didn't know English. You'd have to go through her, and I wasn't impressed with her medical knowledge. The only antibiotic that she was knowledgeable about was penicillin.

It was kind of an insight into international things because I, at least, would talk to people from all over the world that were injured. It was a nice experience. Everybody that was admitted had a specialty consultation from Reno, and fortunately the roads were open. [laughter] Otherwise, I'd have been in deep trouble.

In 1959 was it still the old Highway 40?

Well, no. What had happened was that prior to the Olympics, the full two years I was there, they built the freeway from San Francisco to Reno. The road to Squaw Valley and Kings Beach was, of course, two lane.

The last winter I was there, though, Easter was a big, big ski vacation. I forget

how many people came up, and we had eight feet of snow. For three days the roads were blocked to Tahoe City and to San Francisco and to Reno. For three days we were isolated. A patient came in that went into labor from Tahoe City. She made it to a ski lodge, and the police took a doctor (I can't think of his name) from Kings Beach and I and a nurse, and we carried in an OB pack, and we snowshoed into this ski lodge. I delivered the baby there. He poured the ether — we used ether — and the nurse took care of the baby. Everything turned out OK.

Have you ever snowshoed? It's terrible! It's the worst! One time I was on emergency call because we had to rotate through the emergency room, and we had a call that a guy was having a coronary at a ski lodge that was isolated. So I snowshoed in for several miles, and it was the worst experience of my life. I thought I was going to die. I got up there, and he was just having D.T.'s. So I stayed there, and I finally called and got one of these snowmobiles to come and pick me up. I couldn't have made it back. [laughter] In looking back, you know, I had a lot of fun there.

You probably don't remember Jackie Jensen, but he was one of the most valuable players in the American League. He played for the Boston Red Socks. He had been an All-American football player at the University of California, and he was the basketball coach at the university at Reno before he died. But when he was the most valuable player for Boston, they lived in Lake Tahoe; his wife was Joanne Olsen, who had been an Olympic gold medal diver. They had their first baby up there, and I had to do a Caesarean section on her. So he sent me a baseball signed by Ted Williams and everybody on the team, all the big stars. I gave it to my oldest son. It was interesting; I met more famous people in that

Truckee area because so many people came to Lake Tahoe and to Squaw Valley. It was such a small community, other than the visitors, that you did meet a lot of really fun people.

But you couldn't make a living up there?

Well, I made a living, and if it hadn't been for the emergency room, I probably could have struggled. I think there are two or three obstetricians there now. I probably could have made it, but I just . . . I absolutely hated emergency room work, and I was allergic to plaster of paris. I learned how to do all kinds of orthopedic stuff; I learned to do Kirschner's wires on fractures of the tib-fib and to cast them. It was mostly the San Francisco area people, and we had some orthopedic men down there that we'd send them to.

I can remember the first emergency I saw. I didn't take care of him because Larry Nelson, who I shared an office with, did a lot of orthopedics. But Larry had this Hollywood producer. He'd never been on skis in his life, but he brought this young starlet up with him. He was riding up on the rope tow at Squaw Valley, and he got his skis mixed up, and he fractured both bones in one leg. [laughter] What a trip! [laughter]

You had considered going down to Nevada, to South Shore?

Oh, yes. I realized, you know, after the hours I put in as medical director of the Games, it was just too heavy for me. I always said it was too heavy. So I was looking around, and I talked to a guy who had a lot of money on the South Shore. I think he was into gambling, gaming and stuff. I don't remember his name now. He was from Nevada, though, and he talked to me about relocating. He was going to build an office for me on the Nevada

side. He said that they didn't have a hospital; Barton hadn't been built yet, so I would have to drive into Carson to deliver babies. That would be kind of rough during the winter. I liked it down there, really liked it down there, but that was the reason I didn't go there.

What prompted the move to Las Vegas?

Well, I was looking around for a place to practice. My wife was from California, and I liked the ocean area. So we took about ten days off with the kids in the late summer. We started at Carmel, and we hit every town on the way down. We went clear down to San Clemente. I got the names of obstetricians, and I wrote to all of them; and when they wrote back, they were all discouraging. They didn't want the competition, I'm sure. "Yeah, we got too many obstetricians here," all the way down.

My wife's sister was married to a pathologist who had a big lab in Colton, California, and the pathologist at Southern Nevada Hospital, which is now UMC, had dropped dead. They didn't have anybody to do their pathology, so he would fly up every Sunday and do the surgical specimens and everything. When we finished our tour of the coast, we were visiting my wife's parents in Loma Linda.

My wife's sister was a commercial pilot, and they owned a twin-engine plane. My brother-in-law had to go to Las Vegas that Sunday to do pathology, and he said, "Come on up with us." So we flew up here, and I looked in the phone book, and there were only five obstetricians listed. I thought, "Wow! It's nice up here."

They took us to a show at the Tropicana. It was a Marilyn Monroe look-alike who was killed in an automobile accident in New Orleans, Jayne Mansfield. I went over with him when he did the pathology, and I talked

to the administrator, and he encouraged me to come.

I got all the names of the obstetricians, and when I got back to Truckee, I wrote to all five of them. And I got five letters back begging me to come, saying, "Oh, we really need somebody." I had gotten my Nevada state board, so I made plans to come down, and we made a couple of trips. One of the obstetricians had given my letter to Dr. Freer, who was building the hospital in North Las Vegas. He flew up, and I met with him, and he begged me to come. It was real nice to finally be wanted after all the rejection. [laughter]

So we moved down here, and it was nice. Dr. Freer had been delivering about twenty-five babies a month as a general practitioner, and he immediately turned all his OB over to me, so it was nice. And, you know, I was the only obstetrician in North Las Vegas, and so then there were six obstetricians in town. As soon as I got here, three of them resigned from Southern Nevada Memorial Hospital, just leaving us three on the staff. We had to do all the drop-ins, all the charity work, plus our own practice.

Was there a conflict with the hospital?

Well, Sunrise had just opened up, and then there was a lot of competition. There were two groups; two doctors together went over to Sunrise then. They were with a big group over at Sunrise. I was the third obstetrician on the staff. I was new, so I could get on the staff anywhere. It was really so competitive that they wouldn't let the other three obstetricians on the staff there. Then two of the obstetricians built Women's Hospital because of this. But Dr. Fortier, Dr. Christofferson, and I were the only ones that would go to Southern Nevada, which is now UMC.

There was really a heavy load because at that time everybody was so busy, and we were delivering about forty-five private patients. Every third month we had to rotate through the clinic service; we were on the clinic and doing the drop-ins at the clinic patients. That was about forty-five a month, so the month you were on, you delivered about ninety babies a month. I think that was really unfair that the other three guys wouldn't come.

Is ninety a pretty heavy load?

Oh, yes! Most guys deliver about fifteen now. Fifteen or twenty, yeah. Ninety — that month you never got home. That probably contributed to the demise of my first marriage, because not only every third month you weren't there, but in those days you had to have a consultation even to do a D & C from another obstetrician. That was for a section, for a hysterectomy, for a D & C, for anything you did. So in the middle of the night, if you had to do a section, you called out one of the other obstetricians when you were on call. It was just miserable. That went on for about five years until we had residents.

Now do you not have to have a consultation?

No. This town was really in its formative medical years. There were two factions, the Sunrise faction and the UMC faction, or the Southern Nevada faction, that was really bad. I was kind of in the middle, because I came new and I was on the staff of both hospitals in obstetrics. I got to tell you it was so bad that I was the third obstetrician, and I had the staff there, and I was on the staff up until about 1979. And I never felt welcome there, because I was considered the UMC doctor; I was chief of staff in 1963 and 1966 at UMC. So they treated you bad at Sunrise.

What was the source of the conflict?

It was just like a boiling caldron before they built Sunrise. There were a couple of surgeons that kind of dominated things; they hated each other, and this hatred spilled over into everything else. It was really uncomfortable here when I came here in October, 1959. I just tried to get along. When they built Sunrise, they took a select group of people; about half of the medical people in Las Vegas went to Sunrise. Most of them didn't go then to UMC. A lot of them still did. But it was so horribly competitive.

Was there a large enough population base to support all this?

Well, yes. But in the surgical specialties, there was so much competition. The two major competitors had their own block of people. The guy that went to Sunrise had a large group of people, and if you didn't send patients to him, you were his bitter enemy. It was just bad! And it was really competitive.

So you had personalities conflicting?

Oh, terrible! Like I said, I was in the middle. I was on committees at Sunrise, tissue committees and stuff, and were I to dare raise a voice in something I felt wrong by some of these people, doctors that ran it there, the roof would come down on me.

Were these physicians that had been here for a long time? Who had grown up with the community?

Well, when you say grown up with the community, this is such a young community — before the end of World War II they didn't have any specialists, I don't think,

here at all. I think Dr. Lockwood — he was an EENT man — was about the only one. G.P.'s ran the community. It's interesting because, historically, when they built the dam, they built Rose De Lima Hospital. It was first a government hospital; then the Catholic Church took it over. The only other hospital in the area was Las Vegas Hospital, which was built by about six or seven general practitioners, and they wouldn't let anybody else on the staff.

Jack Cherry — you've heard his name probably — I considered him Mr. Las Vegas. He always had this big diamond ring on his finger, he had a big cigar, he dressed really sporty, and he always had about two thousand dollars' worth of hundred dollar bills in his sock.

He carried money in his sock?

Yeah, in his sock. You'd be in surgery, and you'd see this big bulge in his sock. [laughter] He was a character. I loved him, you know. He's dead now, but he was Mr. Las Vegas. When he came to town after the war, he didn't have hospital privileges. So he wangled some Quonset Huts from the army, and that was the start of Southern Nevada Memorial Hospital. He built that from that.

This is immediately postwar?

Yes. Even then it was highly competitive. Doctors at Las Vegas Hospital wouldn't let the other doctors on the staff. But compared to other areas, even compared to Reno, we're just in our infancy as far as medical history. But it was interesting.

You know, when I was in Truckee, our radiologist was an older woman, really great. She was like a mother to me. She and her husband owned a big resort on Lake Tahoe.

She was real nice, and when I told her I was going to Las Vegas, she cried; begged me not to go. She's dead now, and I can't think of her name, but this was about thirty-four years ago. She treated me like a son. She said, "They'll destroy you in Las Vegas. Medicine is so bad down there."

When I came here, a Dr. Jensen was an internist, and he spent half of his time in Southern California at the University of Southern California teaching. We had Dr. Russell Miller, who had internal medicine training, but was in general practice here. And Dr. Kilduff was a general practitioner; Dr. Jensen taught him how to read EKGs. This is how sparse we were in specialists there.

So whether or not it was their specialty, they just had to fill in?

Yes. For a time, when we didn't have a pathologist at UMC and my brother-in-law wasn't coming up, they let Dr. Cherry do the autopsies. Can you imagine? He was this old general practitioner.

The first seven months I was here, I worked in the emergency room at UMC between eleven and seven, five days a week. I needed some money to support my family until I got on my feet, so I was doing that. A young guy in his thirties brought in this old guy who was about sixty-five and looked like a wino. The history was that they'd flown up to Las Vegas, and the old guy had slipped on some debris in the men's room and hit his head. He had an abrasion on the back of his head, and one pupil was larger than the other. Obviously it was a head injury, and I admitted him.

They had a strange situation in the emergency room at UMC. There were only sixty-five doctors in town, so probably forty of us on the staff there, and you had to

rotate every fortieth night. You could be an obstetrician and get a fracture in, and it was your patient until you called somebody to take care of it.

So I admitted the patient with the head injury. Dr. Sutherland was an orthopedic man, and the next day he called Dr. Verbrughen, a neurosurgeon. The next afternoon — the guy just suddenly died, the old guy. Dr. Cherry did the autopsy, and he knew less about this than I did. [laughter] He signed it out as subdural hematoma. We heard nothing more about it for a year. Then an insurance investigator came up, and he was quizzing me on all this.

I said, "What's going on?" He told me that the young guy was a male nurse, and, suspiciously, about ten people that he had insurance on had died. First of all, it was his nephew who fractured a leg, and he went to visit him, and he died shortly after his uncle visited him. The nurse's mother had insurance. He was living with his mother and eventually his mother died; his ex-wife died, and finally what happened was that they were really suspicious. Shortly after that this nurse married a novelist from Pomona, and she fell unconscious. She was rushed to the hospital, but they saved her, and she had no blood sugar. When she came to, she said that he had given her a shot, which obviously was insulin.

They checked back on it, and in the case I was involved in, the nurse met this old wino and said they would go up to Las Vegas and perform a scam. He'd hit him in the head and put drops in his eyes so one pupil was bigger, and then they would sue the McCarran Airport. They were flying up, and he had a girl friend who was married to a sailor drive his car up. When the guy went in the hospital, they went to a drugstore. I guess then you could buy insulin without a prescription. They bought a bunch of insulin, and then he came that night to put it in the IV, and the

nurse walked in. He was really mad and had to come back the next day. Then they took off for Los Angeles in the car, and they threw the syringe and stuff out in the desert. Well, then the girl got really nervous, and so when all this was going on she told the authorities.

Drs. Sutherland and Cherry and I had to fly down three times, twice for the Grand Jury and once for his trial. The guy got life imprisonment. Then they made a movie of it, a television movie called "Murder One," and Robert Conrad was in it. But they changed it; they made the bad person a woman. [laughter] But it was an interesting case.

I got really close to Dr. Cherry in those days because we were flying down and waiting and everything. When Dr. Cherry was testifying for the trial, suddenly the male nurse fainted. They took him into the judge's chambers, and since Cherry was on the stand, they asked him if he would come in and check the nurse. Obviously it was a fake deal. The judge asked, "What can we do? What can we do for him?" And Cherry said, "Obviously he has high blood sugar; let's get some insulin." [laughter]

What was the response?

The guy came back to life suddenly. [laughter] It was a real interesting case.

I really liked Dr. Cherry. He was an old-time general practitioner, you know, and he'd come from the era when the general practitioners did all the major surgery. He had grandfather privileges, and he did all his surgery until he died.

He practiced in Goldfield before he came here. I heard he graduated from some third-grade medical school. Some people said veterinary school or something like that. He got his license because they really needed doctors down here. I don't know if it's just an apocryphal story; probably is.

In 1968 I was elected as a alternate delegate to the AMA from Nevada. I attended the meetings as alternate delegate with Les Moren, who was the delegate. It was very interesting for me because the mornings of the AMA meetings were taken up with committee meetings; and even though you weren't a member of the committee you attended, you were assigned certain committee meetings, so you could report back to your own delegation. The Nevada delegation met with the California delegation every morning for breakfast, and then the transactions of the committee were gone over during the breakfast meeting. Then we were assigned to certain committees to listen and talk on the floor.

You know, there's a perception of the AMA from the outside, even by doctors who are not involved in the AMA, that it is a very conservative group. But it's my impression that the AMA is, by a long ways, much more progressive than the members. I think it's because members of the AMA are medical politicians, and they're a little more conscious of what's going on in medicine in the country. Also, the liberalism and conservatism in doctors is a geographic thing, like governors from the South tend to be much more conservative than the governors from the Northeast and from the West.

I remember one example that will show you why I think that the delegates are a little more liberal than their constituents. Something came up for a vote in the AMA. I think it was in 1971 or 1972 that it was brought up by the Alaskan delegation to decriminalize marijuana. You'd think this would be a hot button issue before the AMA and they would resoundingly defeat this. But it was only defeated by one or two votes, and that was because of the solid opposition of the South. But this is just a little example of the fact that the AMA isn't that hidebound, conservative organization that's painted.

What were the issues when you were attending?

Well, the Medicare bill had just come up; I think that was in 1965 or 1966. So the implementation of Medicare was a big thing for discussion. I think there was a big change during this time about the insurance situation as far as medicine in general — mainly this big transition from nongovernmental involvement in care to governmental involvement. That probably was a signal issue the four years that I was there.

There were so many bills brought in for discussion, because it's a completely democratic organization in the sense that county medical societies may present something to the state medical societies. If it's passed on by the state medical society, then it's passed on through the delegate from the state to the AMA, and this is what's discussed in committee. All these things that the state societies bring are discussed. Then the committee decides whether this is important enough to be brought to a vote by the delegation. Then the committees discuss all these things that are brought in by the state, and then the committees forward this to the delegates as a whole. Every afternoon the delegates meet, and they each have their own seat with an electronic voting apparatus and then very heated discussions. Then the vote is taken.

It's interesting, the first meeting I ever went to was in New York. As I checked in that evening, there were hundreds of doctors picketing the AMA, mainly very left-wing doctors, a lot of them from New York. They were residents who really wanted the complete takeover of medicine by the government. They had the signs calling doctors butchers, murderers, all kinds of things. They had to increase the security for the AMA because

they were really afraid there might be something with some violence. This was 1966. Of course, that was during the Vietnam War time, when everybody's social conscience was really at a high level and rebellion was rife throughout the land.

Could you tell me a little bit about your association with the Clark County Medical Society?

I've been a member since I came to town probably from the start of 1960, and I had been active in hospital politics. I was chief of staff at Southern Nevada Memorial Hospital, now UMC, in 1963 and 1966, and then on the Executive Committee. I have also have been on the Executive Committee at Sunrise Hospital. About 1966 I was chairman of the first Medical Education Committee of the Clark County Medical Society. At that time we were working with the doctors in Reno to explore the possibility of a medical school, and we met with the men of WICHE in San Francisco. In 1967 I was chosen as president-elect of the Clark County Medical Society, and in 1968 I was chairman of the Clark County Medical Society for a year. At that time the medical society's emphasis was on medical education.

We spent probably the first three months of my term fighting a kind of an insurrection by some of the members. With a previous administration we'd raised a lot of money for the society through a polio immunization program. The previous president of the County Medical Society had utilized some of this money to start the first answering service. It was owned, at that time, by the medical society, and my first baptism as president was kind of an insurrection by a minority of members who were really unhappy with the expenditure of this money. So we spent about

three months in weekly meetings with lawyers trying to get this settled. Other than that, it was a fairly uneventful year.

Based on your involvement with the Clark County Medical Society, what do you feel is the important function they perform as far as medicine is concerned?

Well, I think the county medical society, more than any other medical group, serves as a kind of an area where practicing doctors can discuss issues, not only local issues but state and national issues. It serves as a conduit through which practicing doctors can voice their opinions on local, state, and national health issues. That's the most important thing.

You were chief of staff at UMC in 1963 and 1966, and on the Executive Committee from 1962 to 1968. What does being chief of staff entail?

Well, in this particular era it was really a great change at UMC, because medicine changed here about 1960. When I came in 1960, we had Dr. Jensen, who was the internist, and he spent half of his time at USC teaching and half time here. We had only about six surgeons or eight, and we had six obstetricians in town. In 1962 we had only three obstetricians on the staff, Dr. Fortier, Dr. Christofferson, and myself. There wasn't a lot of specialty, especially subspecialty groups, here.

We were doing all the charity work, all the drop-ins beyond every third month. Our medical education consultant was Dr. Reifenstein from St. Mary's Hospital in San Francisco. He made a lot of visits down with us and formulated a plan with St. Mary's hospital in San Francisco. They had an OB/GYN residency and they would send one to

two of their residents down, and we would supervise them for three months at a time. In 1964, then, we developed the first OB/GYN residency program the state of Nevada had ever had. At that time we had several obstetricians come in that would help with a program, like Dr. Rojas and Dr. DeLee and Dr. Flanagan, so we had maybe four or five obstetricians that came in right at that time that were integral with the program.

Why would residents from San Francisco come to Las Vegas to do a residency?

Well, we had a lot of work. The residents up there weren't getting as much surgery as they thought they needed for a well-rounded exposure in their residency. And we had a lot of surgery, a lot of deliveries. At that time we were delivering forty-five to sixty deliveries a month as far as clinic and drop-ins.

Before we had residents, it was just every third month you had your own deliveries, which in that era were probably about forty or forty-five, your personal deliveries. Then you had to deliver forty-five to sixty clinic and drop-ins. There were only three of us doing that, so you were there just all the time.

So the residents helped?

Oh, they were a godsend. We had the San Francisco program for about six years, maybe. Then Drs. Rojas, Wixsted, and Flanagan, who had come from Tulane, developed a residency through Tulane and Arkansas, which was nice. That continued until we had our own residents through the medical school.

Also during the time I was chief of staff, we received accreditation. We also developed more departmental groups who were given much more responsibility in running the departments of the hospital. During this

time we developed a really great pathology department under Dr. Belliveau. Before it was — you have to understand in 1959 or 1960, medicine in Las Vegas was on a level far below Reno. It was kind of primitive.

But you had a significant population.

Yeah, we did. But like I say, we didn't have really great specialty coverage at that time. I think we had two or three orthopedic men in town; we had an ophthalmologist who did some ENT, and that was the only ENT coverage we had. It was only during the 1960s that they started making some really marked advances in medicine, I think.

In 1966 you were again chief of staff? Had the issues changed a little bit?

Not much. I think there was an increasing sophistication of medicine in Las Vegas. A lot of the doctors that came to town in the early 1960s had come to town for divorces and then stayed here. That was one way we got doctors here. For some reason Las Vegas didn't have the ability to draw a lot of doctors in the early 1960s. Then in about 1964 physicians started coming in. When I came here, I think we had three pediatricians, for example, in town; then that gradually increased. Dr. Carter, I think, was fourth or fifth to come to town. The 1960s were an era that had a really impressive growth in medicine.

I'll just give you a little example of what medicine was like when I came to town. Until I got a practice going, I worked on UMC emergency room from eleven to seven, five nights a week. They got all the trauma. We had about sixty doctors on the staff, maybe fifty or sixty in different specialties. If I had a patient who came in with a broken arm in an accident, I had to call the doctor that

was on call that day, and it might have been an ophthalmologist. Then he had to call an orthopedic man because we didn't have specialties on call. You had to rotate through your night, your day on call. We certainly didn't have much sophistication of medicine in those days.

All of the physicians that I spoke to who came to Las Vegas and started practicing in the 1960s mentioned the opportunity in medicine, that it was a draw.

Yes, there was a great opportunity. In obstetrics right away I started delivering about twenty-five babies a month in the first two or three months. I think the competitive field then was surgery. There was a lot of jealousy among the surgeons, because they each had their stables of general practitioners and other doctors in town that referred to them.

You were delivering twenty or twenty-five babies a month. Now you're cutting back a bit. At the peak of your practice what were you delivering?

About forty-five, which is way too many for personal reasons. I went through two divorces, [laughter] because I was never home. In my first marriage I was so involved in politics and medical politics that I figured that kind of hurt.

How do you function as an obstetrician if you're up all night?

I have a manic personality, and most manics can get by on four hours sleep a night. During this phase you really go, go, go.

Do you have to take medication to control it?

I do now. I do now, because for a long time my depression didn't bother me, but then in the last ten years I noticed that I would be manic for four months. I'm a happy manic; I'm not an aggressive manic or a mean manic or anything like that. I'm just a happy manic. I was noticing I would be four months manic and two months depressed; my depressions are getting deeper, so I take something for that. And I'm fine.

Happy?

Happy! I'm really happy.

You were appointed to the Board of Medical Examiners.

In 1966. I first met Paul Laxalt in 1962 when he ran for lieutenant governor. And I wrote him a check. In 1964 he was lieutenant governor, but he ran for U.S. senator against Howard Cannon. I was also head of the Southern Nevada Committee for Goldwater/Miller, so I met the then lieutenant governor, and I organized doctors and pharmacists and dentists for Laxalt when he ran for U.S. Senate. So I became acquainted with him. Then when Goldwater was defeated, two other doctors, Dr. Belliveau and Dr. Plehn, and I, plus a couple of engineers and some lawyers and some businessmen organized Political Associates which is a Republican support group. I was chairman, and when Republican governors or senators were in town for a convention, we'd put on a luncheon or a dinner, and we'd always have Laxalt down to introduce them.

In 1966 he asked me to run for the state senate, but he asked me just the day before filing closed, and I really didn't have a good chance to get a campaign together. I came in sixth, with five to be elected. In

1968 he was having a lot of opposition from Flora Dungan, who was a really prominent Democratic senator. Every day she knocked him to the press. So he asked me to run in the Republican primary. There were two to be elected, and then Flora Dungan was knocked off the primary. But then I had a really great campaign, and he helped me, and I only lost by six hundred votes.

When he — I'm ahead of myself. In 1966, when he became governor, I was on his executive committee during the campaign and raised money for him. Then Dr. Carter and Dr. Belliveau and I met with Laxalt before he was sworn in, and he said, "You can have any appointment you want." So I chose the State Board of Medical Examiners. That's how I got that. Then later on in two years he appointed me to the Gaming Commission.

So you went on the Board in 1966. What do you think was important that was going on in your time on the Board?

Well, initially, there wasn't a lot of controversy on the Board. With the Board, it was mainly a matter of meeting, interviewing applicants, and passing them or not passing them. There was some controversy with some of the disciplinary things we had to do: probation, maybe one or two licenses taken away. For a while this was about the only controversial aspect of being on the Board.

What do you think were some of the biggest problems that physicians were facing with disciplinary action?

Well, I can remember once we had a doctor — this was probably 1969 — that SAMI had told no surgery except emergency surgery because of the lack of money. The doctor had done a lot of "emergency" surgeries that were

obviously elective surgery. So we had to bring him up and essentially put him on probation. We had a couple of doctors who were put on probation for substance abuse.

With the doctor that was the SAMI issue, if SAMI dictates only emergency surgeries and the doctor chooses to do elective surgery and designated it emergency surgery — isn't this a case of the bureaucracy dictating medicine?

Well, if bureaucracy said you don't have any money, so you can only do emergency surgery, then I think there's a line they draw, and then you don't violate that line. But if you can do elective surgery and somebody else, maybe not even the doctor, makes the decision of whether you can do it or not, that's the problem. That's the point I was objecting to.

I'm a conservative, I think, but indications of any kind of surgery or any kind of treatment have wide parameters. If you are within these parameters, then you are practicing good medicine. But if somebody not involved with the patient arbitrarily says, "You can't do this," when I feel it's within the parameters of good medicine, then I object to that. But if they were to say, "We just don't have the money; we can't do it," then I understand that. And that's the difference.

Five or six years ago, I had a patient that I had done a Caesarian section on because she had a cephalopelvic disproportion. She just didn't have enough room. She became pregnant again a few years later, and doing V-bac, which is vaginal delivery after a section, is really common now. It is probably advisable. But I always take into consideration the patient's attitude, too. If she has had a Caesarian section and absolutely doesn't want to deliver vaginally, then you have to take that into consideration because one of the complications of this is the possibility of

a ruptured uterus while she is in labor. This patient wanted to be sterilized, and she really wanted a Caesarian section. The first one was done because she didn't have enough room, so I scheduled her for a Caesarian section. She'd been offered the other.

She went over the day before the Caesarian section to make arrangements at the hospital, and the hospital talked to her insurance company in Minnesota. I got a call from a lady who wasn't a doctor, who was just a clerk, and she said, "You can't do it."

"What?"

She said, "You can't do it unless you give her a trial labor."

So I couldn't do it. I gave her a trial labor, and she didn't have enough room; I had to do a section. This is what I object to: when your medical judgment dictates something, and yet somebody who's not even medically trained tells you can't do it.

You mentioned some doctors with problems with substance abuse.

Alcoholism, drugs, I think; we had a case where a guy was really mentally unstable, and we took away his license. But we didn't have a lot of doctors in Nevada in the late 1960s, compared to what there are now. We probably examined twenty to twenty-five new applicants every three months. A lot of those doctors weren't coming to Nevada; they just wanted to have a license.

Nevada has, for a long time, had a reputation of being a twenty-four state with the casinos. Statistics are often released the high suicide rates, lung cancer, drinking, that sort of thing. Do you think that has been a factor with physicians? That possibly substance abuse, chemical dependency, is more prevalent among physicians?

I think it has been pretty well proven that substance abuse is more common among physicians than any other profession just because of the availability. If you took the whole country, I think substance abuse is higher among medical people. It's a high-stress profession I think. Probably it is much less a problem now because they have programs; they have physician intervention programs at the hospitals.

But I think there are two things: one is because of the availability of the drugs. The second thing, and you may be too young to remember the 1970s, but during the 1970s I can remember psychiatrists saying in the early 1970s that cocaine was not a habit-forming drug, that it was OK. I think it was just a free-and-easy philosophy not only among doctors but everybody in the 1970s. I think that contributed to doctors and part of the population and drugs — that's the way it was in the 1970s.

I don't think doctors are any more immune and maybe less immune. It's my theory that it is essentially a bunch of obsessive, compulsive people that go to medical school. When you pick applicants for medical school — a lot of it is based on your grades, and I think you have to have a few things; you have to be intelligent, but you also have to have this almost obsessive compulsive desire to perform in order to succeed.

You take just a public university where maybe 10 percent of the people, of the applicants, are chosen for medical school. You have to really strive to be in that group. Even if you're intelligent, you can't goof off or anything. You have to have a certain amount of obsessive-compulsive drive. In any class of medical school, I think you have a much higher percentage of people that are a little bit obsessive-compulsive, don't you think? Don't you think that makes sense?

I've heard another physician say that doctors have healthy egos.

Well, that goes along with it. Right from the time you get in medical school, you are taught by essentially the elite in medicine. And the elite in medicine have a contempt even for practicing doctors. When I was in medical school and I was in L.A. County for a while, practicing doctors would send patients in to the county hospital. Medical students would take the history and in the history there was a little derogatory reference to the L.M.D., the local medical doctor. It was like you were judging him for his diagnosis and things before they were sent in. This was fostered, I think, by the faculty, because they feel that they're being the elite, and they are. But there's a little derogation in their attitude towards practicing doctors.

These are the doctors who are your role models. When you get through, you are making really important decisions every day with patients' lives. It's not true so much now, but in the 1960s and 1970s and even in the 1980s, patients treated doctors with a lot of almost God-like respect. Maybe they didn't like the medical profession as a whole, but their individual doctors were almost like demigods to them. And so this reinforces the ego among doctors.

When you get somebody in this with this personality profile, it's hard to say to yourself, "Well, I was wrong on that." I think, essentially, there is a little bit of denial for two reasons. One is that to maintain this type of ego, I used to say that you shouldn't be delivering babies unless you thought you were the best in town. That's how good my ego was! [laughter] Because if you don't believe in yourself, that you can't take care of everything, that you're not the best in town, then you shouldn't be

doing it. Now, is that egocentric or what? [laughter] I still believe that you should be the best that you can.

And you believe you should believe you're the best?

Yes.

Because there's no time to second-guess your decisions or room for self-doubt?

You don't have any time for second-guessing in an emergency situation. You can't sit and ponder it; you have to do things instantaneously. To be a doctor, it's necessary to have a healthy ego just because you have to make these decisions.

So is it a problem for some physician who might be involved in substance abuse, who has this healthy ego, who has people looking up to him, to do a little self-examination and say, "I've made a mistake, and I'm in over my head." Do you think then there would continue to be denial? Is this a problem?

Even if you weren't involved in any substance abuse, you make decisions, and then you live by those decisions; you can't go back. Then if you're sued or something, you have to defend that decision. So there are very few doctors I've seen in a legal situation who would say, "I really screwed up." You know what I mean? You do the best you can. There should be some self-criticism, but you can't go back and say, "I wish I'd have done something else," because it's already done.

I think this personality and the whole profession makes you live on the edge a little bit because you make these decisions. And I think this type of personality is a little more susceptible to the substance abuse. There's a

tremendous amount of stress and tension, and it's so easy to have a few drinks or to take something that relieves that.

Some of the changes in medicine, like managed care, enable an individual to work a forty-hour week, which is historically not common for physicians. Do you think that this can contribute in some ways to avoiding situations where there would be substance abuse?

Yeah, I think so, because the stress level has to be lower, because you work forty hours a week or whatever, so you're not as fatigued. You don't have this personal commitment to the patient, individual patient. This personal commitment can be really draining. Like today, I just had this older woman who has a ton of personal problems. She sat here for half an hour, forty minutes, talking to me, and this is an emotional drain on the doctor, too. But under managed care you don't have that because it's more of an impersonal type of practice. If you're the type of personality that becomes emotionally involved with your patients' problems, that is very difficult, and increases the stress. Under managed care, you're not going to have this connection with patients when you have a lot of doctors seeing the same patient. It is unfortunate.

One of the issues that was dealt with in the period when you were on the Board was the problems associated with foreign medical schools.

Right. I think this first came to the Board's attention when the medical school started. I remember that they came to us, and there were some professors that they really wanted as far as teaching that were foreign medical school graduates. Up to this time the only ones who could take Nevada boards

were the graduates in the United States and Canada. They had made one exception, Dr. Verbrughen, who was a neurosurgeon here, the only neurosurgeon for a long time, who had graduated in Australia and took his training in Mayo's. But he was the only non-Canadian, non-American graduate who had a license here.

The medical school wanted to bring some professors here that had graduated from foreign medical schools. Most of the other states had allowed foreign medical graduates to apply for licensure who went through the ECFMG and really rigorous testing. In 1971, when we met in Genoa, we redid the whole medical practice act and in this we included approval for foreign medical graduates to apply for licensure. Right after that I went off the Board.

You've been a member of the Board and you are a physician in private practice. What do you see as the most important function of the Board of Medical Examiners?

Well, of course, the primary function is to examine — to maintain the standards of practice in the state as far as not only licensure, but to exert a discipline. I read the other day that Nevada probably has as strict a discipline as any state in the country as far as disciplining doctors. And that's good. That's the primary function of any board.

LEO A. WILNER

Mr. Leo A. Wilner, the son of Russian immigrants, was born in Brooklyn, New York, in 1917. He was a yeshiva student for much of his early schooling and finished high school at Thomas Jefferson High School in Brooklyn, in 1935. He attended Brooklyn College; then moved to Los Angeles in 1936, working and living there for a year.

Returning to New York, he worked at the U. S. Office of Dependency Benefits in Newark, New Jersey, during most of WWII. The Wilners relocated to Los Angeles in 1944, and Mr. Wilner owned and operated a dry cleaning business before becoming the executive director of Judea Congregation in Los Angeles, a position he filled until 1965. In 1966, Mr. Wilner became executive director of Temple Beth Sholom in Las Vegas. He retired from that position in 1984.

Mr. Wilner has been active in community affairs, serving as advisor/counselor to Temple Beth Sholom and Congregation Ner Tamid in Las Vegas. He has also been active with the Advisory Board of the Nevada Division of Aging Services, and the Nevada Commission

on Aging. He was a member of the Board of Medical Examiners from 1985 to 1993.

Leo A. Wilner: I was born in Brooklyn, New York, in the United States of America on January 13, 1917. So that at this time, I'm 77 going on 78. My mother and dad were immigrants. They came from Russia at the turn of the century. My father came, I believe in 1901 or 1902, and came alone. He then subsequently sent for his wife and an older brother of mine and an older sister. I had one other brother who was born in the United States like I was. Of the four of us, there are only two left — my sister, who lives in Hawaii, and myself.

Anita Wilson: Why did your parents come over here? Was it for economic gain?

No, no, hardly. My father was a very religious person and so was my mother apparently, you know, living that kind of life. That's the kind of life I was brought up in — a very religious Jewish life. Judaism in

its religious form was certainly not strange to me as I was growing up. As far as their reason for coming here, I imagine it would be strictly for freedom because they both were in Russia at that time. This was during the years of the Czar, and I think my father was conscripted to be in the army, and he hated it. So he left. I don't know how, but he came to the United States, and then he sent for my mother and the others. Their background is not really completely known to me. When I was growing up, you never questioned your parents; you just accepted them — it never entered my mind to ask, actually.

My oldest brother I knew very little, because he was always away from home; there was a great difference in age between us, about twelve or fourteen years. My other brother was six years older than me. My sister was about eight years older than me.

I saw my older brother occasionally. I used to love to go to his home after he got married. I don't remember the wedding exactly — I was a little boy — but I used to love to go to his home — my big brother and stuff like that. He never had children, unfortunately.

My other brother developed an illness, muscular dystrophy, that eventually took his life. Nobody knows how he got it, why he got it — it was one of those things. Nobody else in the family, nowhere down the line, does anybody have anything of the kind — him it struck. I don't know why, how. Certainly they didn't know.

In those years, he offered himself as a guinea pig to the hospital — I think it was Long Island Medical College — and they should run tests on him. I'll never forget they told him, "Mr. Wilner, we don't need you. We've got youngsters, younger than you, who have the same disease, and we don't know what's causing it." So they didn't need him. But he was this kind of a fellow — when he

died, he willed his body to science so that they could work on his body and see if something could be found that would help others.

What they did with the body, of course, obviously they dismembered it or whatever. But that was his wish. I want to remember my brother the way I remember him, not what happened after he died.

What did your father do here in the United States?

Here, my father was a ritual, kosher slaughterer of chickens and animals. The kosher slaughtering is entirely different than just twisting the neck. This is by law, Jewish law. You have to know exactly how to do it, and not everybody can do it. You have to be approved by a Rabbinical Association and so on and so forth. The Hebrew word is shochet. S-H-O-C-H-E-T, a shochet, which means a ritual, religious slaughterer of animals and fowl.

Is this a trade that you would learn as a young man?

Yes, he learned in his younger years in Russia. Yes, absolutely, you have to learn how, because religious laws are very specific. The knife you use has to be set to such sharpness that it's impossible to describe. Everyday, I remember my father setting on a pumice stone, setting the knife to the sharpness that he wanted, because in Jewish law you're not allowed to torture the animal. The animal has to be killed instantly — instantly — and so the law says. I once studied that, too. The shochet has to kill the chicken by exposing the jugular vein with one stroke of the knife; that's it. If he has to go up and back, then it's not kosher. So there you've learned a little bit about the Jewish law of slaughtering of animals.

Did your mother work in the home?

Oh, yes. Always as a housekeeper, nothing else, just a housekeeper, raised her children; that's it. That was the manner in which we were raised. That was the living my father made, which was sufficient, particularly since the food he got was apparently free or reasonably priced, since that was his field of endeavor.

Was it a rather tight-knit community? Was it primarily a Jewish neighborhood?

No. No, in fact, I've said a thousand times that the street I lived on was a real League of Nations, an honest-to-God League of Nations. There were so many nationalities on that street that I was brought up on that it was absolutely wonderful. Nobody knew from anti-anything, anti-Semitism, anti-black, anti-anything; there was no such thing.

When I was a youngster, we had eight leagues baseball on that street. Baseball, but not the kind of baseball on the fields. This was baseball in the street. We used a stick and any kind of a ball. The ball could have been stuck together with tape a hundred times, but we used it. It was a stick, but it was used exactly the same way as a baseball bat. We made bases on the street, that's all, and, of course we had to get out of the way when a flivver, an old Ford, used to come down the street. So it was beautiful memories, no doubt about it.

The home I lived in had a front stoop which I don't see anymore these days. The stoop had about four steps leading up to a porch, and then you had the entrance to the house from the porch. We used to play stoop ball. You threw the ball against the step, and if you got it back on the fly, it was two points. If it bounced, and then you caught it, it was one point. I mean, these were

children's games, but who knew of TV; who knew of anything in those years? We kept busy, and it was a delightful kind of busy. Nobody knew from problems or anything of the kind. The leagues developed a certain type of — not hate; nobody hated anybody, except individually, who knows? But there was definite competition. Competition was fierce.

A friendly rivalry?

A very friendly rivalry. When the games were over and the leagues were over, everybody celebrated. It was a marvelous set-up for all the kids in the whole neighborhood. Every block had its own leagues. This was all old Brooklyn, New York, quite different from today. Brooklyn was once called the Borough of Homes. It was a beautiful borough. What it is today I don't even want to describe to you. But in those years, it was a Borough of Homes, and that's all it was. Every place, wherever there used to be swamps, became homes. Like here, now, in this state, whatever was the desert yesterday is today homes. That's what happened to New York City in those years.

Did you live in an individual home? An apartment?

I lived in what is called a two-story duplex. There was an upstairs apartment and a downstairs apartment, and we lived in the upstairs apartment. Now, on the same street that I lived on, across the street were tenement houses. Each tenement house had five floors, no elevators, of course not. That's the diversification of the people that lived there. It was every nationality you can think of. But we never spoke of religion — we never spoke of religion. It was always competitive on the basis of sports. Only sports, that's all.

After you got older and moved away from that neighborhood, did you encounter oppression or discrimination? Or unkind words?

Well, unkind words you can find anytime, any place. It's not relegated to only one spot in the universe that somebody can be nasty. We've got enough problems right here in the United States, right here in Las Vegas, right there in Los Angeles, wherever.

You were educated in Brooklyn?

I was a yeshiva student. That's a Jewish parochial school. If you stay through the entire program of education in the yeshiva system, you can become a rabbi. You don't have to, but you may. Many of my classmates did become rabbis but only in graduate form. They did not practice rabbinics. I did not either. I was not interested in rabbinics.

I mean, I was an American kid born in Brooklyn. I loved sports, and it was not in my blood to be a rabbi. My parents, thank goodness, saw the best of it, and did not force me to do it. The educational part I loved; it was very intense education. However, I reached a point in the yeshiva system where there wasn't enough English high school on that level. I was much more advanced in the Hebrew knowledge than in the English knowledge, and there were no more classes in the English available at the yeshiva system at that time. This is going back a lot of years. I had to transfer to an English high school.

I transferred to Thomas Jefferson High School in Brooklyn, New York. While in high school, it's rather interesting, I became the president of the student patrol. Thomas Jefferson High School had the first student patrol of the borough of Brooklyn. It was a marvelous thing. The kids were in charge of everything. I joined it immediately when I

came in, and I was only there two years, four semesters. Well, the fourth semester I went up the rank, so to speak. I was a lieutenant, then a captain in the ranks, and finally I became president of the patrol in my senior term.

What did the student patrol do?

They did everything. They were in charge of all the lobbies, all the staircases, all the lunchrooms, everything that had to do with students. Instead of teachers patrolling, it was a student's patrol. Of course, it was up to us to capture these kids that were out of line. We had a system of cards; I'll never forget that. A white card was first offense; three white cards you got a pink card; pink card went to the dean, and you could be suspended if you got three white cards. So we were pretty important people, the guys and girls on the student patrol. Thomas Jefferson High School, when I went there, had about 7000 students — 700, 800 graduates a semester. That was nothing unusual. So it was a big school.

Was it a general high school? Not specifically science or liberal arts?

No, no, it was strictly a normal high school; everything was taught, everything.

You graduated in the middle of the Depression.

I did. Actually I was supposed to graduate in June of 1934, but my mother passed away in February of '34. Now in the Jewish religion, we say a memorial prayer for the dead. The Orthodox, which I was at that time, have services every day. During the services in the synagogue, you say this memorial prayer for the dead. In order for me to be able to say that memorial prayer every day, properly, with my father, I had to stay home. So I went to

my principal at that time, who was Dr. Elias Lieberman. He's not alive anymore, but he was a wonderful man. I'll never forget him. I asked him for permission to stay over an extra half a year, an extra semester, not to graduate in June, but to graduate in January, because I had to say this memorial prayer every day. He allowed me to do it.

The way he did it was to drop one of the subjects that I needed in order to graduate. It was called economics — these things you don't forget — and I was allowed to drop economics as a course of study. It was only a semester course, that's all it was, but you had to have it and pass it in order to graduate. So I was allowed to drop it. Then my senior six months I really had a ball. I had all fill-in subjects; nothing but economics was my needed subject. Everything else was such baloney. I used to skip the gymnasium and all that stuff. Who needed it? You didn't need it to graduate. Since I was a "big wheel," president of the student patrol, I didn't have to go to those classes. Nobody cared as far as that was concerned, and I did stay over and graduate in January of 1935 instead of June of 1934.

What is your impression of the impact of the Depression?

We didn't know there was a depression. I never knew we were poor. What kid thought about it? We had a roof over our head; we had clothes; we had food. Who needed anything else? We didn't need anything else. So in 1932, from '28 to '32, '33, those were depression years; we didn't know it. My parents, yes. I remember my father and mother talking about some savings they lost in the United States Bank during the Depression years. How much or what, I have no idea. I know they were very sad about it, because it hurt them

terribly. I think they got back 10 percent over the years that followed. That was it.

The Depression years were probably very bad, but we youngsters didn't know it. We were busy; we went to school. Several of my yeshiva classmates were my local rabbi's sons, whom I grew up with. They went to yeshiva, same as I did, so they also had to transfer to Thomas Jefferson High School.

The parents decided, so we wouldn't forget what we learned in yeshiva, that we were going to study with my rabbi. His sons and myself. And that we did for several years after regular high school. In the evening hours if I wasn't busy with meetings or whatnot, we would study with the rabbi for an hour or two so as not to forget our background, our heritage, our Hebraic upbringing, whatever. And it worked out very well.

When I graduated from high school, I needed some money in my pocket. There wasn't too much money to push around in the family, so I got a job. I think my first job, I made something like \$6.00 a week. I felt like a millionaire. It felt good to have my own money and not depend on my parents, who were struggling anyway. That job meant I would go to night school, college night school, and I went to Brooklyn College. Brooklyn College in those years had no campus of its own. We used to travel by streetcar from one building to the next building. These other buildings that we went to were part of other universities, other colleges, like St. John's University. It was in downtown Brooklyn, most of it, but there was no Brooklyn College campus like there is today.

After a year and a half of that, I was thoroughly exhausted. It was impossible to continue. I was working and I started to make a buck, which meant a great deal in those years, you know. So that was it; that was my college career.

I had an uncle who lived in Los Angeles, who was a pharmacist. He and his family lived there for several years, and I had hoped to go to UCLA. When I left New York and came to California to go to UCLA, the same thing happened. I got a good job. I was a big, husky kid, and I got a job driving a truck. I started making \$8.00 and \$9.00 a week in Los Angeles. The fellow working with me was another driver in another truck; it was a beer truck. He was earning \$12.00 a week and he had a wife and two children.

Los Angeles in those years was paradise. I mean, no exaggeration, absolute paradise. This goes back to 1935, 1936, those years. It was marvelous living. With \$8.00, I lived like a king. I'm not exaggerating, not at all. For \$10.00 a month, I rented a cottage which was part of an estate. Originally, somebody like the butler or the maid might have lived in it. It had two rooms and a kitchen, and it was absolutely wonderful to live in that cottage. The cottage came equipped with maid service as far as linens were concerned. All for \$10.00 a month. It was expensive; \$10.00 a month was expensive then.

But I lived like a king! \$8.00 a week! I used to go shopping on a Sunday or a weekend to shop for the week, spend a dollar and a quarter, a dollar and a half. I love oranges to this day. The San Fernando Valley, in those years, was solid orange groves and walnut groves. That's all. There were no residential areas, no businesses, strictly groves. Well, they had an extra amount of oranges that they had to get rid of, especially if they were marked. They called them seconds if they had a scratch on them or whatever — they couldn't ship them out, so they used to sell them. A box which contained an average of six dozen sold for a nickel. A nickel was money in those years, you know; it wasn't peanuts. Today, of course, it's nothing. But in those years, a nickel, a dime did things for you.

Anyway, I fell in love with oranges, and I fell in love with Los Angeles. I was a beer truck driver, and I hated beer. I never drank the beer. But they used to tease me, you know. Anyway, I started earning a good living, and so school was forgotten about. I never went back to school. After that, it became the school of hard knocks — everything on my own, working.

I stayed in California for one year, one year in Los Angeles, living with my uncle part-time until I was able to get my own cottage, and then I got very homesick. I was a youngster, 17 1/2, 18 years old, whatever I was. I got very homesick. I knew my father was alone, but he was in a different world. He was an ultra-religious person. His knowledge was beyond description. Studying every day, Talmud, Talmud, studying, never giving up the studying, all his life.

I called him one day, and I said, "Pop, I'm very lonesome. I want to come home."

So he said, "Come on, come on home. Your room is here whenever you want it."

And so I decided to come home. I bought an old car — it's a car you never heard of. Did you ever hear of the Pierce-Arrow? Pierce-Arrow produced a big car; it was called the Peerless. I bought a 1926 Peerless, it was about 12 years old at the time, and I bought it for \$20.00. The owner had to get rid of it. It was a piece of junk, he said. It was too big; nobody wanted it. So for \$20.00 he gave it to me.

I started cross-country in that Peerless. It was really an expedition. [laughter] My biggest problem with that car was gasoline. The gasoline was dirt cheap in those years, but still, this thing drank gasoline like you and I drinking coffee. There was never an end to how much gasoline it needed. It had a tremendous motor, a tremendous, big motor. It was very safe driving, very comfortable driving. But it needed gasoline. Anyway, I ran

out of money in Columbus, Ohio, and I called my father, and he wired me some money to get me home.

Finally, I made it home. I had to get rid of that car, but nobody wanted it. I used to pile seven couples into that jalopy; it had a jump seat in the back and a back seat. I didn't know what in hell to do with that car — nobody wanted it. Finally a wrecker, a junk dealer, took it from me. He cut the thing in half; he kept the front half and cut off the back half and put his towing stuff on the back half of that car. It became a wrecker, you know, a towing car. That's how big it was. But it got me cross-country.

Anyway, so those were my lonely years in California, but I knew I was going to come back. Oh, I loved California. Oh, it was wonderful, and I knew I would come back.

While I was Brooklyn, New York, I met my wife, fell in love. We got married in March of 1941. Of course, in December of '41 all hell broke loose, but my wife was pregnant at that time, and I was deferred. My deferment came because I started working for the United States Government. I went to work for the IBM, it was called, but not IBM, the company. It was the United States Government, Newark, New Jersey, in their Office of Dependency Benefits — ODB. Now that was the building that took care of all the allotment money of all the service people. It was in the old Prudential Building. You can imagine how much money went through there.

The one mistake I made was signing a contract with the government, because I couldn't advance as far as I could have had I not had a contract with government. The IBM people and other people came looking for people, like myself, who became very adept at the controls of the machines that were being used for printing checks and taking care of any allotment needs of the service people. It

was a mistake to sign with the government, because there you went according to your bracket. You could go up. You know, in Civil Service you go up by brackets, but kids that were out of high school were earning twice as much as I was because they went to the big companies instead of the United States Government. Nevertheless, I enjoyed my work. I really did.

The day came that I wanted to go to California. I asked either for a transfer to someplace in California, or to let me out. Well, they said they'd give me a letter of recommendation, but they couldn't transfer me because they needed me in Newark. So I went to California. I volunteered for several of the services, but they didn't want married men. At that time I had my first son, and a married male with a child was strictly deferred. The service was out, so I decided that my wife, and I and the baby were going to California. Oh, did I love California. So we went. This was in 1944, I believe, just before the end of the war.

It must have been really different since you were last there. California had boom times with the war industries.

Well, it was boom times but everything was on rations in those years — everything. There were green stamps and rations. You couldn't just buy what you wanted; you had to have the green stamps to get it. It wasn't funny. The only things I remember we needed were for the baby: shoes for the baby, and clothes for the baby. For ourselves, we came later; nobody cared. But it was difficult. You didn't get what you wanted in those days; you got what was available.

So anyway, we came to California, and we settled in. I went to work. I got a rather nice job, and we lived with my relatives for

a while until we got our own apartment. I saved up a few cents, went into the business world, opened my own cleaning plant — dry cleaning. This goes back to the late forties, early fifties; my dry cleaning plant was in Inglewood, California, which is a short ride from Los Angeles.

I was in the dry cleaning business for several years, made a very nice living, until one day I got sick from the perchlorethylene. That's the compound that you use for cleaning the clothes. It affected me; I used to work nights and had a lot of business, had to do a lot of work. Several of my clients were from the stables, the racetracks. Their silks used to come in, you know, and they needed it like now, so I used to stay nights and do the work. I overdid it, it affected me, and I got sick from the perchlorethylene. I was hospitalized for about a month, and then the doctor said, "You better stay out of there. There's no point in you going back unless you want to kill yourself." Well, obviously I couldn't, so I took a terrible loss when I sold the business to one of my drivers who used to pick up clothes. And I went out of the dry cleaning business.

You have to understand that I was a religious kid, coming from New York City, from that type of background. I immediately joined a synagogue when we moved to Los Angeles, and I became the elected secretary of the synagogue. Serving in that capacity didn't mean much, but while I was recuperating from my illness, the president of the synagogue said to me, "Leo, you're a young businessman; you're not doing anything now. Come on into the office of the synagogue and help us out. There's no routine; there's no organization. Help us out." He says, "We took in \$26,000.00 last year, and I don't know where it went. We have to have some organization. The only one that's doing anything is this sexton." That's the sexton who takes care of the premises,

you know, for the congregants. But he was an elderly gentleman, and it was not his work.

So, I said to him, "OK, Jack, but if I go in I've got to make a living. Whatever I do, I've got to earn some money."

He said, "What do you need for a living, while you're in the synagogue?"

I said, "Well," with tongue in cheek, I said, "A hundred dollars a week."

"I'll guarantee it," he said.

I said, "You'll guarantee it? OK, you've got a deal. I'll go in and see what I can do." Because I didn't know how long it would take to set up the system. This was 1951. I never left. Never left the business of being the director of the synagogue. In the beginning, I wasn't called anything; I was still the secretary. Eventually I got the title executive director of the synagogue.

The synagogue, thank God, was growing by leaps and bounds because of the organization that I set up. Plus the people started to recognize that it was really an organization and not just a fly-by-night affair. Thank God, I was very grateful to the good Lord that I was successful. I built up a very nice synagogue, and I stayed until the end of 1965.

The name of the synagogue was Judea Congregation. It's no longer in existence. Today, it's a Korean church. Same building, same everything, except the Jewish star. The Jewish stars were taken off the building because now it's a Christian building. But it is immaculate. Those people are wonderful — Korean people. You can eat off the floor; it's that clean. They keep it just right. It's a very good feeling to know that it's not neglected.

In the latter part of 1965, some friends of mine had moved to Las Vegas. Las Vegas, to me, was a "run-away" place, where my wife and I would run away for weekends. Two days; that was it. In those two days, in those years, you could see two, four, five shows; five shows

if you had the strength. We were not drinkers; we never were. But you could go to a midnight show and get a piece of pie and coffee. It was very nice. That's what we used to do, run away for two days, just a total change of atmosphere from the religious life to a non-religious life. I was an American kid; it didn't bother me at all. My wife was, too.

So anyway, Las Vegas was not totally unfamiliar to me because of our visits. Friend of ours from Los Angeles had moved there, and we saw each other whenever we'd go to Las Vegas. In 1965, he called me on the phone. He said, "Leo, we've got a little synagogue out here, and we're growing, but nobody knows what to do with it. That's your background; why don't you consider coming out here?"

I said, "Sam, come on out there? What am I going to do in Las Vegas? What's in Las Vegas except gambling?" Whoever thought there was anything else?

He said, "No, we've got a nice Jewish community here, and it's growing. We don't know what we're doing at the synagogue, and have nothing but arguments amongst the people." They were changing rabbis like every six months. Nobody was getting along with anybody. It's not that I'm the panacea, the Great Solver of Problems, but they needed somebody to organize the place.

Well, the first time he asked, I said, "No way, I can't leave my temple. I'm ecstatically happy here. What do I want to leave for?" This was in early '65. That same year, the temple that I was with in Los Angeles started to change. The atmosphere started changing; the people in the area started to change. Our Jewish people were moving, either to the valley, which is today San Fernando Valley, by then a tremendous residential area, or to Orange County. They were leaving the area of Los Angeles, and we were losing membership. The handwriting was on the wall. I didn't say

anything, but obviously the synagogue was not going to exist without a membership paying dues and making donations.

As the good Lord works in mysterious ways, the call came again from Las Vegas. The president of the synagogue called me on the phone. He was a producer of shows; the show he had at that time was a young comic. You may have heard of him; his name is — God, I can't think of it. He had the "Tonight Show."

Johnny Carson?

Johnny Carson, yes. He was his manager, and Johnny Carson was at the Sahara at that time. The president's name was Stan Irwin. He's still in the business; he's in Beverly Hills now. He's no longer Johnny Carson's manager, but he had others like Pearl Bailey and other actresses and actors, I think. Anyway, he said to me on the phone, "Leo, I'm coming into Los Angeles. I'm staying at a hotel in Beverly Hills." He wanted to meet me because this friend of mine didn't stop talking about me. They really needed somebody who knew what he was doing.

I said to him, "Mr. Irwin, there's no way I'm leaving my temple. I can't. I can't leave them high and dry. No. No money in the world . . ."

He said, "Think about it. Think about it."

I said, "No, no good, I don't want to think about it because I'm not going to leave my temple."

Anyway, the months passed, and by the summer months, July and August, he called again. Mr. Irwin said, "I'm coming to Los Angeles again, and we really want to meet with you, Leo." He said, "I understand that things are changing at your place." And it was true. Things were changing rapidly. So the handwriting was really on the wall, and I knew the place was going to be sold, et cetera.

I became very positive in my attitude, thanking the good Lord that the opportunity was there. I met with him in a restaurant on Sunset Boulevard, in Los Angeles, a famous street, you know, which is Hollywood at its finest. Since that was his way of living, I met with him there. We had lunch together. He was a very handsome man; ooh, what a handsome guy he was. Showgirls used to hang around him all the time. Anyway, I met with him, and it was instant chemical reaction between us. We liked each other very much. He said, "Leo, we want you to come out right now."

I said, "Stan, August is impossible for me. I can come out, but all I can come out for is an interview. I cannot come out to stay because September is the Jewish High Holidays." That's the worst. The busiest time in the world for a synagogue is the Jewish High Holidays. I said, "Let me consider it."

He said, "I'll tell you what, you come out; let me know when you're taking your vacation or whatever. We'll have you meet the executive committee of the Temple Board."

I said, "That's a deal." So in August I took my vacation of about ten days. We were going to spend about three days or four days in Las Vegas to meet our friends, et cetera. So the deal was made. I met with the executive committee. My interview was with five people at the Sahara Hotel in the coffee shop. We sat down at the table — after all, he was a big wheel at the coffee shop at the Sahara. Thank God, they liked me; I liked them. They wanted me to meet the whole board, and they called a special meeting of the board while I was there in Las Vegas, and I was interviewed by the whole board. Anyway, they wanted me immediately.

I said, "There's no way I can come immediately." I told Stanley, "No way. I'm not going to leave before the High Holidays."

They appreciated that finally, and they agreed I would start January 1, of 1966.

Meanwhile, we had a home in Los Angeles, and it had to be sold, you know. As things worked out, I went to Las Vegas and started my job January 1, '66, and my wife had to stay in Los Angeles to sell the home. My younger son, who was at that time at UCLA, graduated. Then he went to school here, what was at that time called Nevada Southern University, and today is UNLV. He got his master's degree there, and then his Ph.D. at the University of Houston.

So it worked out real nice for us. The prices were remarkably cheap in those years, because Las Vegas was mostly desert. But the community was growing, growing. Anyway, thank God, the community fell in love with me, and I fell in love with them. I worked here until June of 1984.

With the same congregation?

Yes. The corporate name is The Jewish Community Center of Las Vegas, Inc., but it is also known as Temple Beth Shalom. Temple Beth Shalom is the largest temple in the state of Nevada, not just locally. We belong to the conservative movement of Judaism. There are three facets in Judaism: orthodox, conservative and reform. We belong to the conservative which is middle of the road.

The congregation was growing as the population was growing. The congregation reached a point where it was impossible to be all things to all people, and so people started breaking away. Today there's an orthodox congregation; there are several reform congregations. But once upon a time all those people were part of my congregation. It used to drive me up a wall trying to make them all happy.

Was it the only synagogue in Las Vegas, then, for a long time?

Yes, that's right. For the longest time, it was the only one, until the mid-seventies; then the other congregations started to form. Meanwhile, the congregation kept growing and growing and growing. It was a wonderful thing to behold. And thank God, I was quite successful. People liked me then, and they like me now. Thank God, I built up a fine reputation.

My retirement party is something I will be proud of the rest of my life. Because there is nobody in my industry, if you will, who ever had such a party. Nobody, nobody.

When I told them I was retiring, everybody was sad. They didn't want me to retire. You know, show biz tells you, and I became pretty familiar with show biz, "leave them wanting more." That's the time to quit. I'd had a bellyful of them. After all, I was in it for roughly 36 years already. Not counting the years that I was not called an executive director, it was over 40 years. So it was enough — time to quit. And leave them wanting more.

I decided that I would retire, and I announced it to my board in 1983. I picked my birthday, January 13, of 1984, as my retirement date. So they said, "Why don't you stay till the end of January?" So, OK. Well, they gave me a party on January 29. The party took place at the Frontier Hotel; there were no strikes at that time, and the entire ballroom was converted into a western atmosphere. I mean everything. The background was totally western, with a jail, a sheriff's office, a saloon, even a house of ill repute, if you will. Everything, the whole ballroom, was the old west.

Everybody was asked to come in western attire. There were about 500 to 600 people,

and everybody who came in got a western hat and a kerchief as a souvenir. Everybody was wearing them during the entire evening. The food for the evening was flown in from St. Louis. The president of the synagogue at that time was from St. Louis, and he knew some kosher restaurants and kosher butchers — everything we had had to be kosher. He brought in three giant barbecues, and there must have been at least 1,000 steaks. They had one special table of pies, a hundred pies. They didn't last.

My wife and I were brought in to the ballroom in an old-fashioned horse and buggy. No exaggeration. We had a room at the hotel for the whole day, where we changed clothes. I bought a western outfit, the whole business, so did the wife. Phew! I get excited even talking about it. Because to see 500, 600 people suddenly stand up and an orchestra, some twelve pieces, blasting out, it was overwhelming. Many of my colleagues still talk about it, those who were there.

What a . . . well, that was marvelous enough. So marvelous that it's hard for me to describe my feelings. How do I tell you how I felt at that time? It was just wonderful. Anyway, to top it all off, they gave me a gift. The gift was a brand-new car.

A brand-new car! I'm still driving it today. I can't get rid of it. It was a brand-new 1984 Oldsmobile Cutlass Supreme. And you know how I got it? It was on the stage. You couldn't see it. When the presentation was made — I'm choking up.

I never expected anything of the kind. I expected them to give me a trip or some kind of a nice gift. After all, to have a party like that. So they opened up the curtain and there was this car. And the president of the temple gave me the keys. I was overwhelmed. But I drive it to this day. I just haven't got the heart to trade

it in to get a better car. I'm telling you, what a gift, what a gift. What a day that was in my life!

I'm executive director emeritus now. I was given the title emeritus, which is the title given to people who deserve it. And I'm also the advisor/counselor to the Board of Directors to this day. Also, I'm advisor/counselor to the Reform Temple that's in the city, because the people who organized that one were also friends of mine. It's been a wonderful career out here. It's been nothing but sensational.

You became involved with the Board of Medical Examiners after you retired.

That's right. In my years as executive director of the Temple, I was familiar with many, many people. Being the only synagogue in town, if anybody needed anything like an invocation, a benediction, they would ask for a rabbi. If the rabbi was not available, they would ask for me, or the cantor. So I became familiar with a lot of people, not necessarily Jewish people, obviously.

Two of these people were young attorneys: one whose name was Harry Reid, and one whose name was Richard Bryan. They were young attorneys, and they went into politics. I hated politics; I still do — I don't like politics at all. I think a person literally has to sell his soul to go into that type of life. But these were two young attorneys who loved it, were dedicated to the welfare of the state, and I think they are to this very day. They're wonderful people. Whenever I'm in Washington, I make it my business to see them and say hello. My closeness with Richard Bryan has not diminished over the years. Of course, you know, they're both senators today, United States Senators.

One day I got a call from a woman, a female voice. This is really cute. The female

voice said to me, "Mr. Wilner, the governor (who was Richard Bryan at the time) would like to appoint you to a board if you accept. Will you accept an appointment to the State Board of Medical Examiners?"

I said, "OK, Herb, enough with this nonsense. Come on, stop kidding around. Don't disguise your voice. What do you want?" Oh, one of my guys who was friendly with me who always used to be a kibitzer on the telephone disguising his voice.

She said, "Oh, no, no, no, Mr. Wilner, I'm really the governor's secretary."

I said, "You are? I'll tell you what. Let me consider the offer. I'll have to talk to my wife and give me your telephone number, and I'll see about it." Meanwhile, I wanted the number to double-check who it is, you know? She gave me a Reno number. I said to my wife, "Well, honey, what do you think?" This was 1985; I was retired already for about a year. Meanwhile, I was getting involved in many things in the city.

She said, "Well, if you want it, honey, take it."

So I said, "OK, let me call back this number." I called back this number, and sure enough the answering person on the other end said, "Governor Bryan's office," and so I knew it was not a fluke, it was not a fake. I spoke to his secretary and told her I would be honored to accept.

October of 1985 was the first meeting that I attended of the Board. The Board at that time, up to that time had been consisting of seven people, I think it was five and two; five physicians and two public members. Then, in 1985 the law was changed to make it nine people; that would be six and three. Six physicians and three lay people, public members. Although the verbiage of public member is wrong because the doctors are also public members, but that was the definition of

what it was supposed to mean. Instead of lay person or a civil whatever, they used public member.

I served on the Board for eight years until July 1, of 1993. Of course, the appointment was for four years, and then Governor Miller, who took over after Governor Bryan became Senator, reappointed me for the second four years.

One of the most fascinating parts of my service on the Board was for the last six years that I was on the Board, I was the one public member on the investigative committee of the Board. Now, this is by statute. The investigative committee must consist of three people — two physicians and one lay person, and that was me. Oh, was that interesting work. This was the committee, you know. This committee could recommend suspension of license, revocation of license, or a slap on the wrist — I mean, whatever we wanted. Then, of course, the final action had to be by the Board. So it was very, very interesting.

My reactions to serving on the Board? To start with, obviously, a lay person is a little bit startled. You keep your mouth shut, and you do a lot of listening and learning, which we did. The work of the Board was foreign to me, obviously. Not that the workmanship was foreign, but the actual focus of the work itself, the intimate workings of the Board was foreign, was very arcane — that's a good word there. But you learn as you go. To learn as you go means you must apply yourself.

In my eight years on the Board, I missed one meeting, and that was the meeting in December of 1984. It was the second meeting that I could have attended, but my wife and I already had tickets for a cruise, and I wasn't about to give up the cruise. So we went on the cruise, and that was the only meeting of the Board that I ever missed.

I loved the Board; I felt its importance; I felt its vitality, and the fact that everybody on the Board was dedicated — not just by law, but really dedicated — to the welfare of the citizenry of our state. There was no question about it in my own mind. I had heard, like I suppose many people have heard, that this would be like the fox watching the chicken coop. You know, doctors taking care of doctors, but it isn't so. At least I'll speak for the boards that I was a member of. These doctors were just as dedicated to the health and welfare of the citizens of the state of Nevada as I was. They took the same oath that I took when I became I member of the Board. You signed your name to an oath, that you're going to be there for the purpose of taking care of the health and welfare of the citizens of the state of Nevada. So, unless you don't care what you're doing, you don't break your oath. When you swear it on, you live by the oath. And it was not hard to live by the oath. That's what it's there for.

Every board is a member of the Federation of State Medical Boards of the United States, which is the national organization. The headquarters are in Fort Worth, Texas, but they meet every year — an annual meeting of the Federation of State Medical Boards. I attended every meeting. The Board used to send me, and I used to love to go to these things, because that's where I really learned a lot. At the beginning it was cute: everybody would approach me and say, "Hi, Doc."

I used to say, "Wait, I'm not a doctor. I'm a public member of the Board." Finally I got tired of saying, "I'm not a member . . . I'm not . . . Come on, you want to call me Doc? Call me Doc. That's all right. I don't care what you call me. I'm there, you know."

I used to make my full reports to the Board from the annual meetings. Once in a while I was appointed to a committee or two

of the Federation. But most important of all, I spoke to the assistant executive director of the Federation. I felt there wasn't enough being done for the lay members of these medical boards. He saw to it at that time, that one part of these annual meetings of the Federation became the public member forum. It's being held to this day at every annual meeting. I was the first speaker at the first public member meeting of the Federation. I'm very proud of that.

What issues did you address?

Issues of my relations to the Board. I wrote two articles that were published in the Federation Bulletin. One was entitled, "Public Member, Where Are You?" Because so few were attending these annual meetings of the Federation, so, "Public Member, Where Are You?" The second article that was published was an article about attitude and perception on the part of a public member of the Board. They don't just publish any piece of junk. I really gave it a lot of effort, and I felt what I wrote. I felt sincerely what I wrote, no baloney involved. I'm, to this day, considered an Honorary Fellow of the Federation. Once you're a member of the Federation, you're an Honorary Fellow when you go off.

Now, as to my reactions on the Board itself. Having developed a rapport with the members of the Board, it was very easy. It was easy to like every member of the Board, even though there were a few changes — people going off the Board, new people appointed to the Board — during my eight years. The chemistry was there all the time, all the time. I loved and respected every one of them. I was the senior member of the Board in years. I was the oldest person on the Board. They respected me — not just because I was older than they are, but I think they respected me

for what I meant to the Board, for my general attitude toward the Board, or whatever it was.

To this day, I have such great love and respect for the people that I know on the Board. I can't describe it. It's just wonderful — right from the first. Everybody, from Dr. Jacobs to our executive director, Pat Perry, who's a wonderful person, to her assistant, to our attorney, Larry Lessly, who I loved as a son all these years. Anyway, the attitude, the chemistry was always there, so that I learned a lot from them, and it has always stood me in good stead. I've never regretted one minute of that so-called labor. I considered it a labor of love.

But it is hard work. There's a lot of material that has to be perused before meetings, particularly for the investigative committee.

No question about it. No question about it. With the investigating committee, the first time we met, where I was a member of it, you keep your mouth shut, and you do a lot of listening and you learn. The idea of being a public member on the Board or on the investigative committee is that you don't butt in on discussions of medical terminology. Obviously, that's strange to me. I don't know medical terminology, except a cold, and what else do we know about medicine? The medicines you can buy over the counter, the names. That's it; you don't know anything about diseases, except for, God forbid, it's in your family. Like my wife passed away of cancer, so I know what cancer is. But other than that, who the hell knows about anything? So you just listen, and you don't participate on that level.

But when it comes to levels of considering ethics, compassion — what? Smoking drugs, taking drugs, alcoholism, substance abuse. That, you just need logic. You don't have to

know any specific terminology involved. That's where I felt that the people on the Board who are lay members could be just as high-on-the-level of any physician. Because when you're talking about ethics and compassion, everybody possesses that ability. You don't have to have any title. That's the way I saw my colleagues who were also on the Board as lay members. I think of the one that's going off the Board, Eva Simmons, or Kathy Ebner from up north. We worked together for all these years. We were the three; there was never anybody else in the eight years that I was on the Board that was a different public member. I respect them very much to this day.

Now, doctors. Obviously, I respect their position. I respect what their knowledge is, and how their reaction is to a patient. I think nobody in the world of physicianry, if there is such a word, respects a patient or considers a patient's welfare more than a doctor who gives his time to the Board. Because that's what his oath says — not just his Hippocratic oath, but the Board oath. He swears that he will take care of the interest and the welfare of the patient or the people.

As far as the Board, it was never like being an underdog or anything of that kind, you know, letting them lord over me — there was never any such attitude on the part of the physicians on the Board. We were truly colleagues in the truest sense of the word.

You said that when you first came on the Board, you wondered if it was a bit of a fox-guarding-the-henhouse situation. You said that wasn't the case at all. Working particularly with the investigative committee, and working with the physicians who had problems, did this change your view of medicine? Did this change your view of physicians?

Well, only to this degree: that it's the rotten apple that spoils the whole basket of apples.

We found that it's probably the one person who spoils that little group. It also lends a rotten apple spirit to the entire profession of physicians. One of the things that I found that was very good was that the physicians had several places where they would send a physician, and not just revoke his license because he was suffering from alcoholism or drug abuse. There was a place where he could go to cure himself, a physicians' own treatment center. It's not like Alcoholics Anonymous where anybody can go, but this was strictly for physicians. I thought this was a wonderful thing.

Basically, they were once good physicians. We don't want to lose a physician if we can help it, especially in a growing state like in Nevada. We don't want to lose a good person. If they made a mistake and they're willing to take the courses that will help them get out of this mess they're in, I was all for it, 100 percent. In fact, it became our routine at the investigative committee to bring back these doctors after they were through with their courses of study at these places. We had them speak to us and tell us their reaction to this cure that they took. Has it worked? Do they really feel cured? The reactions are always positive.

Now, that doesn't mean that immediately they were allowed to go right back into practice on their own. No. We would monitor them, make out a stipulated agreement with the doctor, and monitor whatever field of endeavor he was in, especially a surgeon. If he was a surgeon, he couldn't do any surgery without being monitored right along. Even a family physician, family practice, had to be monitored. And it's not overnight. Our agreements could be for a five-year, seven-year, ten-year monitoring. You don't just go back into practice, just say, "You're cured." Baloney! That's not true. And the agreements

that we make, these are legal agreements, you know, that are drawn up. Three, five, seven, and ten years of monitoring before they are eligible to be their own practitioner without any monitoring.

The worst part of the investigative committee that I found, of course, was in the doctors who took advantage of their patients, sexually. That was a terrible, terrible feeling, on my part anyway. I'm sure that everybody else felt the same way. Many times if the patient would complain they were under some kind of sedation, and the doctor took advantage of them sexually, physically, whatever, it's difficult to prove. The doctor was always able to say the patient was hallucinating, that she or he didn't know what she was talking about. It's very difficult to prove. However, there were cases that were proven.

Working with our Board is different than a civil lawsuit. Civilly, you can sue anybody you want at any time. With our determination, the maximum we could do was fine them financially an amount of money and revoke his license or her license. But that's all we could do. That patient, however, could sue civilly, as well, and collect whatever was awarded by the jury at the time. And you know how juries are today.

The two doctors who served with me as investigative committee people — no question about their dedication to the welfare of the patient. They did a fine job.

There were changes over the years, but because of the way the Board is constituted, the elected secretary-treasurer is automatically chairman of the investigative committee. Dr. Tom Scully is now chairman of that, has been now for several years. I had the privilege of serving with others. There was Dr. Ron Avery, who came on the Board the same time as I did, and he was chairman of the investigative

committee for a couple of years. There was Dr. Delbert Snider. He was chairman of the investigative committee. It was always my pleasure to serve with these people. I loved and respected every one of them, to this day.

Dr. Khan was on the Board. I'll never forget a little incident with him. We came on the Board together, one month apart. The first meeting the minutes came back from the first meeting; they spelled his name K-a-h-n, which is the Jewish way of spelling of Khan. But Dr. Khan is a Muslim. He and I had some beautiful discussions over the years comparing religions. So much of the Muslim and Judaic religions are almost at the same level; they're variations on the same theme. So at that first meeting when the corrections to the minutes came in, I had to make sure they understood that Dr. Kahn was not converting to Judaism. It was a very cute aside, you know, at the meeting.

I always tried not to let the meetings get too heavy. Boy, they could get heavy at times. If I could throw in a word that would make everybody smile or laugh, I always enjoyed doing that.

You said that the maximum thing you could do was revoke someone's license. Taking someone's license away, after all those years of school, of practice, is a big step. That's a momentous decision. Did that weigh on you?

Oh, most heavily, most heavily. No question about it. This was not an easy thing to do. The fact of the matter is that in the eight years, not too many licenses were revoked. Some were, some were. But it had to be an extraordinary case, a very flagrant type of violation. It had to be an inexcusable type of violation, where there's no excuse that the doctor might have. No possibility that you might give credit and say, "Maybe he was

right; maybe this, maybe that.” There weren’t too many total revocations of license. Most of the things that the investigative committee would do was to try and help a doctor straighten out. Like I said to start with, our intentions were to keep a good doctor, not to lose doctors, but to keep them. If we could help them straighten out their lives, that’s what we wanted to do.

It was very effective. No question about it. The investigative committee’s work was probably one of the most effective things the Board could ever do, to straighten out these doctors, who unfortunately fell off the wagon, if you will, or who had drug abuse problems. Occasionally, we had doctors who would sell drugs. Now, these were guys who were more eligible for revocation of license than others. Or sexual abuse was another real heavy, heavy thing that weighed on our minds.

The investigations were extremely thorough. Not just very thorough, but extremely thorough, because as you pointed out so very effectively, this is the livelihood of a person. The life of the patient is primarily important because that’s the oath we take. That’s the first concern, absolutely, of the Board. But the doctor’s life is also a concern. They are human beings. If it’s simply he made a mistake, come on! — the man’s been in practice twenty years and made a mistake? You can take his license. No! If he’s sick, we’re going to help cure him, and let him come back to being the good doctor that he once was. But if he’s really a terrible person to have in the medical profession, if he’s a black sheep, get rid of him. Get rid of him! That’s the time to do it. So the analysis was very important and the investigators’ work had to be complete and thorough — I mean to the nth degree, before any kind of action would be taken.

Then, of course, we would call in the doctor and have them sit on the so-called hot

seat, when we interviewed him and asked him very pointed questions, face-to-face.

What kind of attitudes did you see when the physicians came in?

Well, most of them had appreciative attitudes. They thanked us for what we did, especially those who came back to practice, even though they were monitored. But they had been given the chance of correcting their errors, and they were very grateful, expressively so, and said so publicly. There were others who resented being called by the investigative committee, and those are the guys we watched very carefully, very carefully, because if they indeed were making mistakes, a repeated mistake — remember the law is specific; the law is specific.

There was a time when I didn’t understand it; it’s very difficult to understand. It’s interpretive law. It speaks of malpractice and gross malpractice. My contention to the Board was — and I stated it complete and clearly to the Board on more than one instance — that I as a public member didn’t care; there’s no difference in my mind between malpractice and gross malpractice. What the hell does that mean to me? If the doctor did something to my family, and I consider it malpractice, I don’t care what you call it. It’s malpractice, period! But the law is different. It’s got to be repeated malpractice, or gross malpractice.

Gross malpractice was the attitude, “I don’t give a damn about this patient.” Now, how many doctors are going to say that? So the investigation had to determine that, in speaking to the doctor personally and by getting investigations of his background, of possible other complaints against him, records that we might have — all this was taken into consideration. Occasionally you met that type of doctor. You met the liar,

and, boy, when you found out he was a liar, you were anxious to see that he got what was coming to him. But that doesn't happen very frequently.

A vast majority of the physicians that we took care of, so to speak, that we cured of their malady, were very, very thankful and grateful. And one thank you from a doctor was all the pleasure that I ever wanted — to know that this man or woman straightened up, and that they're back in practice helping people. That was a great feeling of accomplishment, no doubt about it.

One of the things that happened while you were on the Board was the hiring of a lobbyist. How did you feel about the increasing complexity of the Board's function?

Well, it was very important. The population of the state was growing by leaps and bounds. So many things were taking place with the legislature that met only every second year, every two years. So many things were happening that we had to know, if it affected medicine. None of us could go up there and sit in Carson City while the legislature was in session — that's obvious. So in order for us to be familiar with what's going on, we had to do what hundreds of dozens of other companies and organizations are doing, had done at that time, and that is hire a lobbyist. It was the job of this lobbyist to report to the Board anything that was on the docket of the assembly or the senate that had to do with medicine in any way, shape or form, to give us an idea of what's taking place. We had to know in order for us to know clearly how to do the work of the Board. It was definitely very important.

The laws keep changing. I'll never know why, but they keep changing it, becoming more complex with each passing year. Now, when I came on the Board, Larry Lessly was

already the attorney for the Board, but he was in private practice, as well. It was his personal determination, which I was very happy to hear, that he wanted to be on the Board only, to give up his private practice. He became our full-time attorney working for the state; became a state employee. I was delighted. Larry Lessly is a fine attorney; he's completely familiar with every aspect of the Board and the law of medicine, et cetera, et cetera. He's steered us straight and narrow all the time. He met with us, and the investigative committee, as well. He meets with every committee that has anything to do with the Board. So he sees that we don't do anything wrong.

We also have a representative from the attorney general's office who sits with the Board at every meeting. In a case where we are taking a doctor for hearing, OK? Our attorney, Larry Lessly, becomes the prosecutor. And the attorney general's representative becomes the Board's attorney at that time. It's a female now, Paige Underwood. Paige has been with them several years now. We had several of them during the eight years when I was on the Board.

You said that you felt when you came on the Board as a public member that the Board was doing a good job of looking at physicians. Do you think public members are necessary?

Oh, absolutely. There's no question in my mind. Because we never want the ability of a person to say that it's the fox guarding the henhouse. Doctors are just as honest about their approach to the welfare of the citizen as I am, but the public member guarantees to the citizen of the state that the physicians are not taking advantage of the law to suit the physician, and the hell with their patient. No such thing.

I used to come back from these Federation meetings on my Board, and realize that Nevada takes the back seat to nobody. I'm very proud of Nevada, lots of things that we did. In fact, at a Federation meeting for a public forum, I remember telling them that we are one of the few states that have three public members. One-third of our Board are public members. There were so many states at that time that had no public members. Many of them had one public member, and a few had two public members. Nobody had three, except Nevada.

Would you go on the Board again?

Oh, I'd love to. In fact, I tell them to change the law. Get the law to change to one year between, instead of four years. [laughter]

APPENDIX A: MEMBERS, NEVADA STATE BOARD OF MEDICAL EXAMINERS, 1899-1995

MEMBERS, NEVADA STATE BOARD OF MEDICAL EXAMINERS 1899-1995

Original Board Members, 1899:

Guinan, J.	Carson City
Lee, S.L. 1899-1903, 1905-1907, 1913-1916	Carson City
Phillips, P.T. 1899-1902	Reno
Fee, George 1899-1901	Reno
Wagner, Philopena 1899-1905	Carson City

Subsequent appointments, reappointments:

Hood, W.H. 1900-1904	Battle Mountain
Samuels, W.L. 1901-1905	Winnemucca
Garner, J.L. 1905-1909	Tonopah
Circe, W.J. 1905-1906, 1908-1912	Carson City
Lewis, J.A. 1905-1906, 1910-1917	Reno
Gardner, G.M. 1905-1909, 1919-1923	Fallon
Sullivan, J.J. 1906-1908, 1910-1914	Virginia City
Richardson, R.H. 1910-1913	Ely
Wheeler, E.A. 1913-1917	Goldfield
Morrison, S.K. 1913-1922	Reno

Mangan, P.J. 1914-1919	Winnemucca
Grigsby, E.S. 1915-1919	Tonopah
Gibson, S.C. 1917-1919	Reno
Olmstead, A.C. 1919-1921, 1923-1927	Wells
Edwards, W.M. 1919-1923	Mason
DaCosta, A.R. 1922	Reno
Robinson, J.L. 1926-1930	Reno
Shaw, W.A. 1926-1932	Elko
Muller, V.H. 1926-1928	Reno
Hamer, H.H. 1927-1935	Carson City
Howell, W.L. 1927-1938	Gardnerville
Creveling, E.A. 1927-1935, 1945-1948	Reno
Brown, H.J. 1928-1937	Reno
Roantree, R.P. 1932-1953	Elko
Worden, J.E. 1936-1940	Fallon
Bowdle, R.A. 1938-1946	East Ely
West, C.W. 1939-1945	Reno
Magee, G.R. 1939-1943	Yerington
Cantlon, V. 1939-1943	Reno
Anderson, F.M. 1940-1942	Carson City
Petty, R.A. 1942-1943, 1960-1969	Carson City
Ross, G.H. 1943-1961	Carson City
Balcom, R.D. 1943-1946	Las Vegas
Hovenden, O. 1944-1948	McGill
Slavin, H.B. 1946-1951	Las Vegas
Frolich, W.H. 1949-1953	East Ely
Maclean, K. 1949-1979	Reno
Moren, L.A. 1950-1977	Elko
Eklund, R.N. 1951-1955	Las Vegas
Ross, T.V. 1953-1961	East Ely
Collette, G.A. 1953-1954	Elko
Hardy, S.L. 1955-1967	Las Vegas
Anderson, R.J. 1965-1971	East Ely
Turner, K.E. 1967-1971	Las Vegas
Grundy, R.D. 1969-1980	Carson City
Zucker, R. 1971-1975	Las Vegas
Cammack, K.V. 1971-1977	Las Vegas
Jacobs, T. 1975-1995	Las Vegas

Kaye, H. 1977-1980	Carson City*
Crockett, I.M. 1977-1980	Las Vegas*
Christensen, G.N. 1977-1981	Ely
Scully, T.J. 1977-1985, 1988-1996	Reno†
Prior, E. 1980-1984	Reno*
Carter, A.J. 1980-1988	Las Vegas
Simmons, E.G. 1980-1994	Las Vegas*
Baker, R.H. 1981-1989	Las Vegas
Clift, R. 1983-1987	Reno
Ebner, K.L. 1984-1996	Reno*†
Avery, M.R. 1985-1993	Reno
Khan, I.U. 1985-1993	Las Vegas
Wilner, L.A. 1985-1993	Las Vegas*
Snider, D.E. 1987-1992	Carson City
Nagy, M.N. 1989-1997	Las Vegas†
Baggett, R.T. 1992-1999	Carson City†
Buchwald, S.S. 1993-	Reno
Countess, J.D. 1993	Las Vegas*
Desai, D.K. 1993-	Las Vegas
Rosencrantz, A.D. 1993-	Las Vegas*
Scaramosino, V. 1994-	Las Vegas*
Stewart, P.A. 1995-	Las Vegas

* Public members.

† Scheduled end of term.

APPENDIX B: FIRST EXAMINATION ADMINISTERED BY THE BOARD OF MEDICAL EXAMINERS, 1899-1900

FIRST EXAMINATION ADMINISTERED BY THE BOARD OF MEDICAL EXAMINERS, 1899-1900

Surgery and Pathology

1. Describe inflammatory action.
2. What is a compound comminuted fracture?
3. How would you treat a simple fracture of the femur at its central portion?
4. How would you treat septicemia locally and constitutionally?
5. Give differential diagnosis of hernia, hydrocele and varicocele.
6. Classify carcinomata.
7. What is meant by term "infection," as used in a surgical sense?
8. Describe Potts' fracture.

Physiology

1. Describe briefly the circulation of the blood.
2. What are the functions of the lymphatic glands?
3. Give the reaction of normal urine.
4. Describe the physiological process involved in the healing of a wound by granulation.
5. What classes of food are digested in the stomach alone?

Chemistry and Toxicology

1. Give chemical formula for water, nitric acid and common salt.
2. Give chemical reaction of elixir of vitriol.
3. Name some of the medicinal substances that should not be placed in the same mixture with fluid extracts.
4. What are the antidotes for carbolic acid, bichloride of mercury, morphine, alcohol and ergot?
5. What is hydrogen peroxide and in what percentage of dilution is it ordinarily used?

Eye, Ear, Nose and Throat

1. How would you treat a simple acute conjunctivitis?
2. How would you treat acute otitis media suppurative?
3. How would you plug the nasal cavity anteriorly and posteriorly for nasal hemorrhage?
4. How would you treat laryngitis in the adult.
5. How would you treat globus hystericus?

Therapeutics

1. What is meant by therapeutical indication?
2. Give physiological actions of digitalis, uses and dose of the tincture.
3. Write a prescription for the cough in acute bronchitis.
4. Give dose of tincture nucis vomicæ, sulphate of strychnia, arsenite of strychnia, codeine, ipecac et opii pulvis.
5. Write a prescription containing chloride of iron, dilute phosphoric acid, strychnia sulphate, glycerine and syrup of orange peel; give dose, and in what conditions it would be useful?

Hygiene

1. What is hygiene?
2. What elements are necessary to retain good health?
3. What should the conditions of our houses be?
4. What precautions in regard to contagious diseases?

Diseases of Children

1. Describe the foetal circulation.
2. What is rachitis and what its pathology?
3. What are the complications, sequelæ, prophylaxis and treatment of scarlatina?
4. What are the symptoms, sequelæ and treatment of measles?
5. What is the difference between measles and roseola?

Gynecology

1. Describe the discharges of the female genitalia, their sources, appearance and properties.
2. What is anti-flexion?
3. How would you make the diagnosis of a tumor by palpation?
4. What is amenorrhœa, pathological and physiological?
5. What is dysmenorrhœa? What are the varieties?

Theory and Practice of Medicine

1. Define general medical pathology.
2. What is histology? Of what does it treat?
3. What is meant by fatty degeneration of the heart? What changes take place?
4. What is leucocythæmia?
5. What are the zymotic diseases?
6. What are the eruptions of smallpox called in their various changes, from their first appearance to the stage of suppuration?
7. Diagnose lead colic.
8. What is gastralgia? Diagnose it.

Genito-Urinary Diseases

1. What is the most frequent cause of a continued glutty discharge after an attack of gonorrhœa?
2. What is balanitis? What causes it?
3. How many separate and distinct contagious diseases result from venereal contact? Name them.
4. What is tubercular syphilide?

Genito-Urinary Diseases (cont.)

5. What is hypospadias?
6. What is the difference between a Hunterian chancre and a chancroid?

Physical Diagnosis

1. What is physical diagnosis?
2. What are the six methods used in physical diagnosis? Describe briefly their application.
3. What are the two classes of rales or rhonci? Name the varieties.
4. What does auricular diastole and ventricular systole mean?
5. How many sounds has the heart? How many murmurs?
6. What is the action of alkaline urine on red litmus paper?
7. What disease would be suggested to you if the urine had a specific gravity of 1007? What if it had a specific gravity of 1035?

Obstetrics

1. What is tubal pregnancy? What are the two immediate dangers of tubal pregnancy?
2. What membranes cover the foetus? Name them and state their relation to the foetus.
3. What foramen is found connecting the right and left auricle in the foetal heart?
4. What veins carry arterial blood in the foetus?
5. What symptoms would most strongly suggest placenta previa to you?
6. What is the average period, in days, of pregnancy? What were the two extremes that legitimized the child in the Code of Napoleon?
7. What is the position of the uterus during the first two months of pregnancy?

Anatomy

1. How many bones are there in the carpus? Name them in order from the radial to the ulnar side.
2. What valves guard the orifice of the pulmonary arteries? What guards the auriculo-ventricular opening on the left side of the heart? What surrounds the orifice of the aorta?
3. What is the average weight of the brain in the adult male?
4. Bound Scarpa's triangle.
5. How many bones in the tarsus? Name them.

Anatomy (cont.)

6. What is the sesamoid bone? Name one or more.
7. Name the principle muscles of the abdomen?
8. How many small bones of the ear? Name them.

Report of State Board of Medical Examiners, *Appendix to Journals of Senate and Assembly*, 20th sess., 1901 (Carson City: State Printing Office, 1901), 4-7.

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